

ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:
Moving to High Quality, Adequate Coverage:
State Implementation of New
Essential Health Benefits Requirements

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally.

INTRODUCTION AND METHODOLOGY

The Patient Protection and Affordable Care Act of 2010 attempts to improve consumers' access to adequate, affordable health insurance coverage through a set of comprehensive market reforms. These include new requirements that insurers guarantee issue policies to all applicants and set premium rates without regard to health status, as well as meet minimum standards for the adequacy of coverage. Beginning January 1, 2014, insurers selling non-grandfathered¹ individual and small-group policies must ensure they include 10 categories of essential health benefits (EHB) and restrict consumers' out-of-pocket costs.

Establishing a meaningful but still affordable EHB standard generated considerable debate at the federal level and in many states.² While benchmark standards have been established for all the states, officials and some health care stakeholders point to continuing implementation challenges, including tight time frames for product development and regulatory review, the need for timely and effective federal/state coordination, potential increased costs for consumers and small business purchasers, and the appropriate balance between a standardized benefit design and the flexibility for insurers to innovate.

This paper focuses on state implementation of the EHB standard. We do not assess state action on other important components of coverage affected by the ACA, such as consumer cost-sharing and network adequacy. To perform

this analysis we reviewed state legislation, regulations, and guidance, and conducted in-depth telephone interviews with health insurance regulators from departments of insurance (DOIs) and insurance industry representatives in five states: Alabama, Colorado, New Mexico, Oregon, and Virginia. See table 1.

Table 1: State Oversight of Plans Inside and Outside the Exchanges

State	Type of Exchange	Oversight for Exchange Plans	Oversight for Plans Outside the Exchange
Alabama	Federally facilitated	Centers for Medicare and Medicaid Services (CMS)	State law: Alabama DOI Federal law: CMS
Colorado	State-based	Colorado DOI*	Colorado DOI
New Mexico	State-based	New Mexico DOI*	New Mexico DOI
Oregon	State-based	Oregon DOI*	Oregon DOI
Virginia	Federally facilitated; state conducting plan management	Virginia DOI and Virginia Department of Health*	Virginia DOI and Virginia Department of Health

**Oversight conducted on behalf of the exchange*

Three of these states (Colorado, New Mexico, and Oregon) are each running their own exchange and the DOIs are

performing reviews for products inside and outside the exchange. One state—Virginia—has a federally run exchange, but its insurance department is conducting the regulatory review for products inside and outside the exchange and performing certain plan management functions with the assistance of the Virginia Department of Health. Alabama, by contrast, has ceded much of its regulatory authority to the federal Centers for Medicare and Medicaid Services (CMS). State regulators note that they lack authority under their state code to enforce federal law, but the DOI has historically reviewed health plans for compliance with pre-ACA federal health insurance laws (such as the Health Insurance Portability and Accountability Act, or HIPAA). In March 2013, Alabama’s governor informed CMS that the state does not intend to enforce any part of federal health care reform, which state officials interpret to include pre-ACA federal law. As a result, CMS is required to directly enforce both the ACA and pre-ACA federal health insurance laws, inside and outside the exchange.

This paper provides an assessment of respondents’ experiences with the development and regulatory review of health insurance products that meet the new EHB standards. Major findings include:

- Technical glitches and tight deadlines posed challenges for insurers and regulators alike, but an “all hands on deck” mentality and commitment to consumers have kept the product development and review process moving forward.
- Officials in all but one state reported that they have had good, if not always timely, communication with CMS regarding plan management and oversight.
- Insurers and regulators in most study states reported that the shift to an EHB standard would cause minimal change or disruption, but one state noted it would result in a significantly expanded set of benefits for individual policyholders.
- Insurers are engaging in minimal substitution of covered benefits in the first year, meaning that plans will closely resemble the benefits, limits, and exclusions prescribed in the benchmark package, with differences primarily reflected in cost-sharing and network design.
- States are adapting to new requirements to review plans for discriminatory benefit designs and coverage of habilitative services.
- One study state is facilitating consumers’ ability to make “apples-to-apples” plan comparisons by standardizing benefit designs inside and outside the exchange.

BACKGROUND

States have traditionally led government efforts to improve the adequacy of benefits covered by private health insurance plans, primarily in the form of benefit mandates.³ Mandates can come in many forms, including requirements to cover certain services, health conditions, or specialty health care providers.

While all states currently have at least some benefit mandates in place,⁴ the individual health insurance market—and, to a lesser extent, the small-group market—have often failed to provide all consumers with adequate health coverage due to gaps or limits in the benefits covered by a plan, as well as high levels of cost-sharing for covered benefits.⁵ For instance, it remains common for individual market plans to not offer coverage for maternity care, mental health and substance abuse services, prescription drugs, and other items and services. When these or other benefits are covered, they are often subject to restrictions on how much or when a health plan will pay.⁶ Even in the small-group market, coverage of certain benefits, such as behavioral health care and pediatric oral and vision services, is often limited.⁷

Affordable Care Act Requirements

To address these gaps and ensure consumers can access a common core set of benefits, the ACA calls for the Secretary of the U.S. Department of Health and Human Services (HHS) to define a set of essential health benefits to be offered by all new fully insured individual and small-group health plans, beginning January 1, 2014. This requirement applies to insurers selling both inside and outside the new health insurance exchanges. The law stipulates that the EHB must include at least the items and services within the following 10 general categories of benefits: 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.⁸

To guide the secretary in defining the essential health benefits, the ACA provides that the scope of the benefits

must be equal to that provided under a typical employer plan.⁹ In addition, the secretary is required to ensure that there is an appropriate balance among the 10 categories and take into account the health care needs of diverse segments of the population—including women, children, and persons with disabilities—and is prohibited from making coverage decisions or design benefits in ways that discriminate against individuals on the basis of age, disability, or expected length of life. S/he also must ensure that the items and services within the EHB are not subject to denial to individuals against their wishes on the basis of age or expected length of life, present or predicted disability, degree of medical dependency, or quality of life.¹⁰

Health plans are permitted to provide benefits in excess of the EHB.¹¹ However, such benefits would not be subject to the ACA's prohibition on annual and lifetime limits,¹² nor would they count toward the value of premium tax credits¹³ or be covered by the additional subsidies to reduce cost-sharing for low-income consumers.¹⁴ States may continue to mandate benefits in addition to the EHB as well, but if they do, the law requires that they defray the cost of additional benefits for individuals enrolled in qualified health plans.¹⁵

Federal Rules

Rather than define a uniform, national set of essential health benefits, HHS provided that each state could choose a benchmark plan on which to base their EHB package. In selecting their benchmark, states were allowed to choose among 10 options: the largest health plan by enrollment in any of the three largest small-group insurance products in the state; any of the three largest state employee health benefit plans; any of the three largest plans offered to federal employees; and the largest commercial health maintenance organization (HMO) plan in the state.¹⁶ If a state did not make a benchmark selection, it would default to the largest health plan offered in the largest small-group product in the state.¹⁷

Recognizing that the benchmark options may not include all 10 categories required under the ACA, the secretary ruled that such plans must generally be supplemented through the addition of an entire missing category from any other benchmark plan option.¹⁸ In the case of pediatric oral and vision services, states could choose to supplement their chosen benchmark plans with the benefits provided by a Federal Employee Dental and Vision Insurance Program Plan or a state Children's Health Insurance Program plan.¹⁹ In addition, because

habilitative services are not currently well-defined and may not be explicitly included in many plans, the secretary provided that the state may determine which benefits must be included to meet the habilitative services requirement if the benchmark plan is lacking in this category.²⁰ If a state does not do so, insurers may fill in this category by either covering habilitative services in a similar scope, amount, and duration as rehabilitative services or by determining their own level of coverage and reporting this to HHS.²¹

The secretary also specified that the benchmark plan must not include discriminatory benefit designs²² and must ensure an appropriate balance among categories.²³ However, mechanisms to assess whether a benchmark plan meets these standards and, if not, to bring it into compliance were not provided in rulemaking.

Health plans will be allowed to deviate from the benchmark package so long as they provide benefits that are "substantially equal" to the benchmark in terms of covered benefits and limits.²⁴ Unless prohibited by a state, a health insurer may substitute one benefit for another within a category so long as it submits certified evidence that the benefits are "actuarially equivalent."²⁵ With respect to prescription drug benefits, a health plan must cover at least the greater of one drug in every category and class in the United States Pharmacopeia or the number of prescription drugs in each category and class as the benchmark plan.²⁶ Health insurers covering the EHB are also prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation,²⁷ and plans will not be considered to provide the essential health benefits if its benefit design, or the implementation of its benefit designs, discriminates on the grounds described in the law.²⁸

Implementation

Twenty-four states and the District of Columbia submitted formal benchmark plan selections to HHS; all but five selected one of the small-group benchmark plan options. By not selecting a benchmark plan, the remaining 26 states defaulted to the largest small-group plan by enrollment in the state. Some states, such as California, took action to define habilitative services and prohibit or discourage benefit substitution.²⁹

In the spring of 2013, states began reviewing rates and forms for the 2014 plan year. While standards and practices vary, states typically require health insurers to submit policy forms to demonstrate that their plans are

in compliance with state laws and regulations. In some cases, states permit insurers to “file and use” their rates and policy forms. In other words, insurers are allowed to use their premium rates and plan designs without state review, as long as the information is on file with the DOI. Other states require regulators to review and approve rates and forms before they can be used.³⁰ State reviews can often take 60 to 90 days or more.³¹

Implementation of the ACA’s 2014 market reforms and new health insurance exchanges in every state presents many new challenges for insurers and regulators alike. First, both are facing more compressed time frames than normal. A number of federal regulations affecting the terms and pricing of insurance products—including rules on the EHB, cost-sharing requirements, and rating practices—were not finalized until late February,³² just two months before insurers were typically required to submit their rates and policy forms to participate in health insurance exchanges. In states operating state-based exchanges or conducting plan management functions on behalf of the federal government, regulators must finish their reviews of exchange plans by July 31st so plan information can be integrated accurately into state and federal IT systems ahead of open enrollment.³³ States may choose to review plans intended to be sold solely off of exchanges on the same or a different timeline.

Second, both insurers and regulators in most states must adjust to the new and unprecedented role of the federal government in plan review and oversight. The degree of federal involvement will vary based on two factors: the state’s role in exchange implementation and the state’s willingness and ability to enforce ACA market reforms.

In the 14 states conducting plan management on behalf of the federally run exchange,³⁴ the state is responsible

for reviewing plan rates, covered benefits, and cost-sharing requirements and making recommendations that plans meet exchange certification standards to HHS.³⁵ HHS will review state recommendations and make final certification decisions, work with insurers to upload and verify exchange information for display, and enter into agreements with insurers to complete the certification process. Insurers will be expected to use the federal data system, the Health Insurance Oversight System (HIOS), to request a plan identification number and a state data submission system, typically the System for Electronic Rate and Form Filing (SERFF).

In other states with federally run exchanges, the state will continue to conduct its traditional rate and form review process while the federal government will review plan information for certification. HHS anticipates integrating any information made available by the state in its reviews; however, insurers will need to go through both processes independently, including submitting plan data through both HIOS and SERFF.³⁶ In addition, some states have also informed the federal government that they will not or cannot enforce the ACA’s 2014 market reforms. In these states, all insurers, regardless of whether they want to participate in the exchange, are required to submit policy forms to the federal government to review for compliance with federal law in addition to following their state’s rate and form review processes.³⁷

In states operating state-based exchanges,³⁸ there will be less need for coordination between state and federal officials during the plan review and approval process. However, even in these states, insurers will need to work directly with the federal government in other regards, as HHS will be operating some or all of the premium risk stabilization programs (risk adjustment, reinsurance, and risk corridors) depending on the state.³⁹

FINDINGS

Technical Glitches and Tight Deadlines for Product Filing and Review

Insurers in the five study states were faced with tight deadlines for the submission of their products—both exchange and non-exchange—to state regulators for review. See table 2. The federal government’s final EHB regulation was not published until February of 2013, and additional, critical details for insurers developing

exchange plans were not released until early April.⁴⁰ Even after this guidance was published, insurers and state regulators alike reported that CMS continued to issue evolving instructions that in some instances completely reversed their prior understanding of the agency’s policy. As a result insurers had only a few weeks to file their plans for review in a very fluid regulatory environment. As one insurance company representative put it, “One of the bigger [challenges] was speed—trying to complete and file our products in time.”

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The rush and technical glitches required “workarounds” and caused mistakes. During the filing process, HIOS, and to a lesser extent, SERFF, suffered from technical problems. “The HIOS system—it seems like it was kind of propped up. I know people were working hard, but there wasn’t much time to test it,” observed one insurance company representative. Another labeled the process “frustrating and challenging” due to the technical problems.

Table 2: State Filing Deadlines for Policy Forms*

State	Filing Deadline for Exchange Plans	Filing Deadline for Plans Outside the Exchange
Alabama	May 3, 2013	State deadline: 60 days prior to offering for sale Federal deadline: 60 days prior to offering for sale**
Colorado	April 1, 2013 to June 30, 2013	April 1, 2013 to June 30, 2013
New Mexico	April 30, 2013 (extended due to technical problems)	August 15, 2013
Oregon	April 30, 2013	April 30, 2013
Virginia	May 3, 2013	May 3, 2013 (if insurer also filed to sell plans on the exchange)

*Sources: State Department of Insurance websites and interviews with state officials.

**CCIIO, *Form Filing Instructions and HIOS Training Webinar Memo*, April 1, 2013. Available from <http://www.cms.gov/CCIIO/Resources/Training-Resources/Downloads/issuer-form-filing-instructions-04012013.pdf>.

As the filing deadline approached, DOI staff and insurance companies took an “all hands on deck” approach to make sure filings were submitted properly and on time. “In some cases we held hands [with the insurers] until the wee hours in the morning to work through the [technical problems],” one recalled. And although the filing deadline had passed at the time of our interviews, DOI staff were continuing to collect information from insurers who had needed “workarounds” to get their submissions in on time. “Because this came down to the wire, there wasn’t time to do this thoughtfully or carefully,” observed one regulator. Another has found numerous problems with insurers’

filings. “With the tight time frames, [the insurers] were just hastily putting [filings] together—a lot of things were missed in the rush to get them in.”

The filing of thousands of new, ACA-compliant plans has also generated concerns about the capacity of DOIs (and for the federally facilitated exchanges, of CMS) to complete their reviews in a timely way, so that plans can be available in time for open enrollment in the new health insurance exchanges. “The [essential health benefits] have added a whole new level of form review and it’s a lot more than we have had to look at [in the past],” observed one DOI official. “We’ve done some cross-training [of staff] but we’re...stretched very thin.”

Other DOIs have engaged in triage. New Mexico’s DOI, for example, required insurers to submit exchange plans by April 30, 2013, but asked insurers offering products outside the exchange to hold off submitting their filings until August 15, 2013. Although this approach may allow the New Mexico DOI to better manage the volume of filings, other respondents noted that the different filing deadlines for plans offered inside and outside the exchange could potentially lead to “gaming, adverse selection, and other anti-competitive problems.” The New Mexico review team has also prioritized individual market filings over those for the Small Business Health Options Program (SHOP), in the hopes they can get their exchange contractor to accept the SHOP filings later in the process. Regulators in another state suggested that the deadlines established by CMS for the review of QHPs would have to shift. “At some point this immovable deadline has got to move or some concession has to be made...maybe to stagger things by priority.”

In spite of concerns about DOI capacity and looming deadlines, DOI officials expressed confidence that they would maintain a rigorous review process. “We are more interested in...the policyholders,” asserted one DOI official. “We need to make sure the contracts are clear and accurate, or they will be of no benefit to the policyholder.” This commitment to consumers and willingness on the part of insurers and regulators alike to find solutions to technical and operational challenges has kept the product development and review process moving forward in all the study states.

With One Exception, States are Working with CMS to Conduct EHB Reviews

Among our study states, all but one DOI reported that they have had good communication with CMS regarding

plan management and oversight. However, some complained that CMS was not always timely in answering technical questions or helping DOIs interpret federal rules. State DOIs reported that they would sometimes need to get out in front of CMS on an issue, or fill in gaps in federal guidance and hope that CMS would not later put out guidance contradicting the state's interpretation.

Not all states are working closely with CMS to provide guidance to insurers on the ACA's market rules. In Alabama, for example, the federal government is not only conducting plan management for the federally facilitated exchange, it is also directly enforcing the ACA's market rules inside and outside the exchange.⁴¹ However, the state is far from abdicating its role as an insurance market regulator and will continue to review health plans for compliance with health insurance protections under state law. Officials noted that they would continue to require all companies to file the necessary forms with the state, for both exchange and non-exchange products. What this actually means for insurers and consumers is still a bit of a mystery, especially if the state were to approve a filing that CMS did not approve. State regulators noted that there is no clear mechanism or process for informing CMS of state decisions or requests to amend insurance company filings. As recently as June, Alabama insurance company representatives were uncertain how the review process would work. "We're still trying to figure it out," they said.

Other insurance industry representatives working directly with CMS to develop and file plans have expressed some concerns about their interactions. Some have observed that federal officials lack sufficient experience and understanding of state markets and industry dynamics. Further, they complain about the deluge of new guidance from CMS—hundreds of "frequently asked questions" have been posted, requiring insurers to revise and retool their product filings, up to and even after the filing deadlines. Insurers also found that the CMS help desk did not have sufficient capacity to answer questions in a timely way. "They'd take a question and then take a few days [to get back to us]," noted one insurance company representative. "They seemed to really struggle to handle the volume."

New Benefit Requirements have a Smaller Impact in States with Many Pre-ACA Benefit Mandates

Among our study states, those that had key benefit mandates in place prior to the enactment of the ACA, such as Colorado and New Mexico, indicated that the shift to an EHB standard would cause minimal change or disruption. For example, Colorado regulators asserted that because the state has mandated coverage of a number of key benefits over the last several years, the most recent being a maternity benefit for individual health plans, the shift to an EHB standard is "not a big issue" in the state. Similarly, New Mexico state regulators highlighted that they have historically been a "heavily mandated" state, resulting in very little difference between individual market and small-group market policies. Oregon regulators noted that some of their insurers already provide robust coverage, so shifting to the EHB standard would not be a "big lift." And even though other insurers will need to make "major changes" to comply with the EHB standard, regulators did not anticipate that it will be a major driver of premium increases.

Most insurance industry respondents suggested that they made minimal changes to their products to meet the ACA's new EHB standards, even if they were not the issuer of the state's selected "benchmark" plan. For example, an insurer in Colorado found that the benefits covered in their products were not very different from those in the state's benchmark, offered by Kaiser Foundation Health Plan: "Our plan and the Kaiser plan were extremely close so we didn't make many modifications." And a New Mexico insurer concluded that the EHB requirements were a "non-issue" in the state because their benefits had already been rich. Among insurers who did offer the selected benchmark plan, the changes were even less dramatic, requiring

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only the addition of pediatric vision and dental and a few other small adjustments. “It wasn’t a drastic change for us,” one observed.

In Virginia, by contrast, individual market policyholders will have access to a significantly expanded set of benefits. Maternity care has not traditionally been covered in their individual market, and, according to regulators, some insurers also offered policies that did not cover prescription drugs. Because the new EHB standard requires individual market plans to cover these benefit categories, individual policyholders are likely to gain access to more a broader range of benefits.

For most insurers, substitution represented an actuarial and administrative headache that they calculated not worth the trouble.

Overall, in spite of initial concerns from some observers that the adoption of a new benefit standard would result in dramatic changes to insurance policies—and commensurate increases in cost—regulators in most study states reported that it did not result in a major market change. In the one state suggesting a greater impact, regulators noted the significant expansion of benefits for individual policyholders.

For 2014, Insurers are Engaging in Minimal Substitution of Covered Benefits

While all of our study states are allowing insurers to substitute benefits within the statutorily prescribed benefit categories, some have actively discouraged the practice. For example, Virginia’s DOI advised insurers that “actuarially equivalent substitutions...are permitted,” but they are warned that “such substitutions may result in significant delays in the review of their form and rate filings.”⁴² Oregon enacted a law requiring insurers to offer standardized bronze and silver plans in order to facilitate consumers’ ability to make “apples to apples” comparisons among plans and prohibiting benefit substitution in those plans.⁴³ Perhaps as a result, state officials in the study states consistently reported that insurers are not filing plans that substitute benefits. “I’ve only seen one minor benefit substitution [relating to nursing home coverage] so far,” one regulator noted.

Consistent with these findings, our insurance company respondents reported that they were not substituting benefits in their plans, at least not for 2014. For most, substitution represented an actuarial and administrative headache that they calculated not worth the trouble. “As an actuary,” one health plan representative noted, “it’s hard to guess what [CMS] means by ‘actuarially equivalent.’ There’s a lot of room to argue [about what it means].” Such arguments with regulators would cost time and resources—costs that insurers can ill afford. Other insurers observed that the federal regulations had effectively “shut down” any attempts to design a plan to attract or repel certain populations. “When we finally saw [federal] regulations, it became clear that plan design would be simple and straightforward and not a matter for agonizing over,” said one insurance company official.

As a result, some insurers predicted that competition will occur primarily around product pricing, and not around benefit design: “From the beginning we assumed that the plan designs that we would offer and that our competitors would offer would be very similar.... The angst is around pricing.”

To the extent insurers do engage in substitution, several of our DOI respondents indicated they will independently review the assertions of actuarial equivalence. As one DOI reviewer put it, “I will view [the filing] for whether the substitution is reasonable and ... is explained well. Otherwise we might ask for more information.”

Given insurer trepidation about moving forward with significant substitution, plans will closely resemble the benefits, limits, and exclusions prescribed in the benchmark package in the first year, with differences primarily reflected in cost-sharing and network design. However, substitution remains an issue to monitor. While some insurers declined to engage in much substitution this year because of concerns about oversight, tight deadlines, and administrative costs, it is possible that over time they will find it an attractive way to differentiate themselves as the initial burdens of ACA implementation dissipate.

Confusion Over the Lack of a Clear Review Standard for Discrimination in Benefit Design

Both insurers and regulators indicated they have little experience assessing whether a plan’s benefit design discriminates against less healthy people, and the lack of a clearly defined standard for what constitutes

discrimination has made the review process challenging. “There is no standard for identifying discriminatory benefit design yet,” noted one regulator. However, some DOIs intend to use a software tool developed by CMS, which is designed to identify certain outliers in a plan’s benefit design and flag them for more in-depth review. Regulators suggested that this tool will be critical. “We don’t know how we would do [the review] without it,” asserted one state regulator.

In that vein, Colorado has published guidance for insurers on discriminatory benefit design, informing them that the DOI will “compare benefit designs for outliers,” and assess limits and restrictions in plans, including visit limits and prior authorization requirements associated with specific benefits. The guidance further provides specific benefits that will get a close examination, such as in-patient hospital stays, inpatient mental/behavioral health stays, and prescription drugs.⁴⁴ Similarly, Virginia and Oregon regulators indicated that, while they have traditionally conducted comprehensive benefit reviews, the new non-discrimination requirements mean they’ll need to take a closer look.

Table 3: State Benchmark Plans and Supplemented Categories*

State	Benchmark	Supplemented Categories	Does Benchmark Include Habilitative Services?
Alabama	Blue Cross Blue Shield of Alabama 320 Plan	Pediatric Oral Pediatric Vision	Yes
Colorado	Kaiser Foundation Health Plan of Colorado Ded/HMO 1200	Pediatric Oral	No
New Mexico	Lovelace Insurance Company Classic PPO	Pediatric Oral Pediatric Vision	Yes
Oregon	PacificSource Health Plans Preferred CoDeduct Value 3000 35 70	Pediatric Oral Pediatric Vision	No
Virginia	Anthem Health Plans of VA PPO	Pediatric Oral Pediatric Vision	Yes

*Source: CMS, *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*. Available from <http://www.cms.gov/CCIIO/Resources/Data-Resources/ebb.html#Alabama>.

Insurers expressed little concern over the new non-discrimination standard, generally presuming that their own benefit designs were not discriminatory. “It’s not been a big concern for us,” one insurer noted. Others joked that they were not smart enough to design discriminatory benefit designs. “Cleverer people may have figured it out,” one said, “but I’d be surprised if I saw anything that was fundamentally discriminatory.”

To date, none of our study states have notified an insurer of a discriminatory benefit design among their plan filings. However, it is unclear at this time whether the lack of reported enforcement actions stems from widespread insurer compliance or instead from regulators’ lack of a clear definition or standard with which to assess benefit designs. As plans are marketed and sold, it will be important for regulators to monitor the experience of policyholders, particularly those with significant health care needs, in obtaining necessary care at a reasonable cost.

Supplementing Benefits: Some States Defined Habilitative Services for Insurers

None of the state benchmark plans cover all 10 of the statutorily required benefit categories. See table 3.

All but one state had to add both the pediatric dental and vision benefits. The coverage of habilitative services was more ambiguous. This ambiguity is consistent with HHS’ findings nationally. In their review of habilitative coverage in employer-sponsored health plans, they identified no generally accepted definition of habilitative services among health plans, and found considerable variation in the breadth and depth of coverage.⁴⁵

In our study states, both insurers and regulators told us that while benchmark policy documents indicated habilitative services were not covered, in actual practice, some insurers paid habilitative claims. For example, CMS’ summary of Virginia’s benchmark plan (based on information provided by the insurer) indicated that habilitative services were included. See table 3. But state regulators told us that their own analysis of the benchmark plan suggested habilitative services were not covered.

Given the ambiguity, three of our study states—Virginia, Colorado, and Oregon—provided insurers with a published definition of habilitative services that must be included in contracts to comply with the EHB

requirement. For example, Colorado’s guidance defines habilitative services as

“...services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado’s EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.”⁴⁶

But even with this guidance, at least one insurance industry respondent felt that the definition of habilitative services was “left ambiguous.” However, some of our insurer respondents indicated they would just “copy what we have on the physical therapy side” to comply with the requirement to cover habilitative services.

New Mexico did not provide published guidance on habilitative benefits, but will conduct plan reviews to assess compliance with the ACA’s requirement to include coverage of habilitative benefits within the EHB package. By contrast, Alabama allows insurers to define habilitative services and will defer to CMS to review whether insurers are in compliance.

Habilitative services are included within the EHB because Congress concluded they were a critical component of any comprehensive benefit package. However, our findings indicate that what constitutes habilitative services, as well as the appropriate amount, duration, and scope of coverage for these services, remains poorly defined. Some states have attempted to guide insurers on these questions to encourage a minimum standard of coverage; others are letting insurers decide. As policyholders begin using their new benefits, it will be important for state officials to monitor their access to care in order to determine the extent to which their coverage meets their needs.

Oregon Moves Forward to Standardize Benefit Design Inside and Outside the Exchange

In order to facilitate consumers’ ability to make “apples-to-apples” comparisons among health plans, Oregon’s legislature enacted a law in 2011 requiring insurers to market standardized benefit designs at the bronze and silver levels of coverage.⁴⁷ This requirement applies to individual and small-group policies inside and outside the state exchange, and the Oregon exchange, Cover Oregon, additionally requires participating insurers to offer a standardized gold plan.⁴⁸ However, while the exchange limits insurers to only two additional non-standardized plans at each coverage level, insurers are not limited in the number of non-standardized plans they can offer outside the exchange.

The Oregon DOI was charged with designing the standardized plans. Regulators reported that they attempted to match what was currently popular in the market. At least one insurance company respondent indicated support for standardized plans, suggesting it would benefit consumers to easily compare plans across key dimensions such as price, quality, and network. Oregon respondents indicated that insurers are complying with the standardization rules.

Oregon is one of six states—including California, Connecticut, Massachusetts, New York, and Vermont—requiring insurers to offer standardized plans on the exchange. Other states, such as the District of Columbia, are considering doing so in the future.⁴⁹ Oregon’s experiences with standardization and the impact on consumer decision-making and plan choice will undoubtedly be closely watched by state and federal policy-makers.

CONCLUSION

Developing health plans that comply with the ACA's 2014 market rules has been no small lift for insurers in our study states, and the review and approval process has stretched the capacity of state DOIs. However, in spite of technical glitches, most companies were able to meet federal and state filing deadlines and insurance departments have implemented practical approaches to manage the significant expansion.

At the same time, in a majority of our study states, consumers are unlikely to see dramatic changes in the scope of their covered benefits, in part because states had pre-ACA benefit mandates in place. However, there

remain long-term questions about the extent to which individual and small-group policies will conform to the state's benchmark benefit package. In this first year, while benefit substitution was allowed in all of our study states, insurers and regulators alike reported minimal activity in this area. And one state, Oregon, is requiring insurers to market a set of plans that have not only a standardized offering of benefits, but standardized cost-sharing as well. In addition, new ACA requirements, such as the prohibition against a discriminatory benefit design and coverage of habilitative services, present new compliance and review challenges for insurers and regulators alike.

ENDNOTES

1. A “grandfathered” plan is one that was in existence as of the date the ACA was enacted (March 23, 2010) and to which there have not been substantial changes in benefits or cost-sharing. Many of the ACA’s market reforms, including the guaranteed issue, rating, and EHB standards, do not apply to grandfathered plans.
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3. Some notable exceptions include a selection of federal laws that apply minimum coverage requirements to certain group plans or employers offering health insurance coverage, including the Mental Health Parity, the Mental Health Parity and Addiction Equity Act, the Newborns’ and Mothers Health Protection Act, the Women’s Health and Cancer Rights Act, and the Pregnancy Discrimination Act. Claxton G, “How Private Health Coverage Works: A Primer, 2008 Update,” *The Henry J. Kaiser Family Foundation*, Apr. 2008; and Sarata A, “Mental Health Parity and the Patient Protection and Affordable Care Act of 2010,” *Congressional Research Services*, Dec. 28, 2011.
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9. ACA § 1302(b)(2)(A).
10. ACA § 1302(b)(4).
11. ACA § 1302(b)(5).
12. ACA § 1001, adding new § 2711(b) to the Public Health Service Act.
13. ACA § 1401, adding new § 36B(b)(3)(D)(i) to the Internal Revenue Code.
14. ACA § 1402(c)(4).
15. ACA § 1311(d)(3)(B).
16. 45 CFR §156.100(a).
17. 45 CFR §156.100(c).
18. 45 CFR §156.110(b)(1).
19. 45 CFR §156.110(b)(2).
20. 45 CFR §156.110(f).
21. 45 CFR §156.115(a)(5).
22. 45 CFR §156.110(d).
23. 45 CFR §156.110(e).
24. 45 CFR §156.115(a)(1).
25. 45 CFR §156.115(b).
26. 45 CFR §156.122(a).
27. 45 CFR §156.125(b).
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29. Corlette S, Lucia K, and Levin M, “Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan,” *The Commonwealth Fund*, Mar. 2013.
30. Claxton, “How Private Health Coverage Works: A Primer, 2008 Update,” 2008.
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33. Center for Consumer Information and Insurance Oversight, “Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges,” 2013.
34. These states include Arkansas, Delaware, Illinois, Iowa, Kansas, Maine, Michigan, Montana, Nebraska, New Hampshire, Ohio, South Dakota, Utah (for the individual market only), Virginia, and West Virginia. Dash S, Monahan C, and Lucia K, “Implementing the Affordable Care Act: State Decisions about Health Insurance Exchange Establishment,” *The Center on Health Insurance Reforms, Georgetown University Health Policy Institute*, Apr. 2013; and Government Accountability Office, “Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges,” GAO-13-601, June 19, 2013.
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37. As of March 29, 2013, six states—Arizona (with respect to their group PPO market only), Alabama, Missouri, Oklahoma, Texas, and Wyoming—had informed HHS that they do not have the authority to enforce or are not otherwise enforcing the market reforms in the Affordable Care Act. Center for Consumer Information and Insurance Oversight, “Compliance,” accessed June 21, 2013, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html>.
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