Joint Informational Hearing

Assembly and Senate Health Committees

Background on California's Health Insurance Mandates and Essential Health Benefits
Wednesday, February 19, 2020—1:30 p.m.
State Capitol, Room 4203

PURPOSE OF THIS HEARING

In 2019, the Legislature passed AB 598 (Bloom), requiring health insurance coverage of hearing aids. This bill would have been the first time California enacted a health insurance mandate that would have exceeded California's essential health benefits (EHBs) and would have required the state to pay costs associated with that benefit mandate. AB 598 was withdrawn from the engrossing and enrolling process. Governor Newsom's 2020 budget proposes to create a state program to assist families with the cost of hearing aids and related services for children without health insurance coverage for households with incomes up to 600% of the federal poverty level. The discussions related to AB 598 highlighted the need for a review of California's mandates and the role of EHBs. Given the size and complexities of California's health care system, it is necessary to consider the impact of increasing benefits and services when evaluating an EHB expansion or new health care mandate. The purpose of this informational hearing is to provide a brief overview of existing California health insurance coverage mandates, including a discussion of California benefit mandates, the California Health Benefits Review Program (CHBRP) process, and EHBs.

BACKGROUND

Prior to the enactment of the federal Patient Protection and Affordable Care Act (ACA), covered benefits under a health plan or insurance policy varied from policy to policy. For example, in California some state-required covered benefits (or coverage "mandates") applied only to health

care service plan contracts offered by health plans regulated by the Department of Managed Health Care under the Knox-Keene Health Care Service Act of 1975, while others applied to health insurance policies offered by health insurers regulated by the Department of Insurance under the Insurance Code. Today, most mandates apply to both health plan contracts and health insurance policies. However, there are three different market segments: individual; small group; and, large group, where carriers sell products that meet market-specific requirements. In some cases a mandate may apply to one, two, or all three market segments. In group products, there are also some mandates to "offer" coverage (versus a mandate to cover). California has an expansive range of benefit mandates that includes basic health care services, cancer screenings and treatment, AIDS vaccines and treatment, diabetes education and treatment, behavioral health treatment for autism related disorders, severe mental illness, and hospice care. For more information, CHBRP has a resource that describes health insurance benefit mandates in California and under federal law.

The ACA required health plans and insurance policies offered in the individual and small group markets to provide a comprehensive package of items and services, known as EHBs, with no dollar limits. Under federal law, EHBs require plans to cover 10 categories of services: (1) ambulatory patient services (outpatient care); (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (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 dental and vision care. The ACA helps consumers shop for and compare health insurance options in the individual and small group markets by promoting consistency across plans, protecting consumers by ensuring that plans cover a core package of items that are equal in scope to benefits offered by a typical employer plan, and limit out of pocket expenses. Federal rules outline health insurance standards related to the coverage of EHB and the determination of actuarial value (AV) – (which represents the share of health care expenses the plan covers for a typical group of enrollees), while providing significant flexibility to states to shape how EHBs are defined. Taken together, EHBs and AV significantly increase consumers' ability to compare and make an informed choice about health plans. The ACA also specifies that if states require plans to cover services beyond those defined as EHBs in law, states must pay the costs of those benefits.

California's EHB benchmark plan selection process. Under the ACA, individual and small group plans and policies sold on and outside of health benefit exchanges (in California, Covered California) are required to ensure coverage of EHBs. In 2011, the federal Center for Consumer Information and Insurance Oversight (CCIIO) released an EHB bulletin requiring that EHBs be defined using a benchmark approach. This approach gave states the flexibility to select a benchmark plan that reflected the scope of services offered by a "typical employer plan." If a state did not choose a benchmark health plan, the default benchmark plan for the state would be the largest plan by enrollment in the largest product in the small group market as of the first

quarter of 2012. The final rule provided that all plans subject to EHBs offer benefits substantially equal to the benefits offered by the benchmark plan. This approach best struck the balance between comprehensiveness, affordability, and state flexibility. The final rule also gave issuers the flexibility to offer innovative benefit designs and a choice of health plans, but required EHBs to include coverage of services and items in all ten statutory categories required in the ACA. While the ACA allows a state to require benefits in addition to the EHBs, the state must pay for the premium cost associated with those additional benefits/mandates. State mandates enacted before December 31, 2011 (like basic health care services under the Knox-Keene Act) are considered part of the EHBs and the requirement that the state pay the costs of these mandated benefits is waived. States were permitted to choose among the following benchmark health insurance plan options:

a) One of the three largest small group plans in the state by enrollment;
b) One of the three largest state employee health plans by enrollment;
c) One of the three largest federal employee health plan options by enrollment; or,
d) The largest HMO plan offered in the state's commercial market by enrollment.

In January 2012, Covered California retained the Milliman consulting firm to analyze and compare the health services covered by the ten EHB California benchmark plan options. The analysis was used by stakeholders as part of the decision making process for selecting California's EHB benchmark plan that became effective January 1, 2014. Milliman found all the plans to be comprehensive and found there to be only a very small cost difference between the optional plans. AB 1453 (Monning, Chapter 854, Statutes of 2012) and SB 951 (Hernandez, Chapter 866, Statutes of 2012) made the Kaiser Small Group HMO (Kaiser plan) California's benchmark plan, which was also the default plan had California not made an affirmative choice. Since the Kaiser plan did not include items or services within all ten of the mandated categories, the Kaiser plan was supplemented in the areas of pediatric vision and pediatric dental services.

EHB Selection for 2017. A subsequent federal rule issued by CCIIO required states to use 2014 plans to define EHB, starting with the 2017 plan year. For California, the 2014 selection process largely mirrored the prior selection process conducted in 2012. The benchmark options and default plan were the same ten categories as in 2012. Additionally, according to the federal rule, if the benchmark did not include coverage of habilitative services, the state needed to determine which services were to be included in that category. The federal rule indicated states should consider a federal definition of habilitative services and devices to determine if coverage exists, and indicated there was no need to defray qualified health plan subsidy costs if a new mandate was needed to supplement the habilitative coverage category.

Milliman again analyzed and compared the health services covered by the ten plans available to California as options for California's EHB benchmark effective January 1, 2017. Milliman found

relatively small differences in average healthcare costs among the 10 benchmark options. Milliman found differing coverage of acupuncture, infertility treatment, chiropractic care, and hearing aids. The three California small group plans were essentially the same average cost as the current California EHB plan and the California large group and CalPERS plans were approximately 0.2-1.0% higher. The estimated average costs for three other options were approximately 1% higher than the California EHB plan.

At the time, some stakeholders recommended a change in the selected EHB benchmark plan from the Kaiser Small Group HMO 30 plan to the CalPERS Kaiser HMO. According to the Milliman analysis, there were coverage differences between the two plans. The CalPERS Kaiser HMO included coverage for hearing aids (with coverage limits) and infertility treatment. While both plans provided coverage for home health care, the Kaiser Small Group HMO 30 covered 100 visits per year. The CalPERS Kaiser HMO did not limit the number of visits per year. Milliman estimated that with these coverage differences, selecting the CalPERS Kaiser HMO would result in an increase in allowed costs by 0.38%. Other coverage differences between the two plans included coverage by the CalPERS Kaiser HMO for certain categories of prosthetic and orthotic devices, as well as eyeglasses or contact lenses following cataract surgery. These coverage differences were not factored into Milliman's cost estimate. The Legislature, with stakeholder input decided against the CalPERS HMO due to the increased costs, and again chose the Kaiser Small Group HMO with the passage of SB 43 (Hernandez, Chapter 648, Statutes of 2015). SB 43 also contained the federal definition of habilitative services and devices.

For plan year 2020 and after, new federal rules give states the option to establish new standards when updating EHB benchmark plans. According to the rule, a state may change its EHB benchmark plan for plan years on or after January 1, 2020 by: a) selecting the EHB benchmark plan that another state used for the 2017 plan year; b) replacing one or more categories of EHBs in the state's EHB benchmark plan used for the 2017 plan year with the same category or categories of EHBs from the EHB benchmark plan that another state used for the 2017 plan year; or, c) otherwise selecting a set of benefits that would become the state's EHB benchmark plan. The scope of benefits must be equal to, or greater than, the scope of benefits of a typical employer plan, to the extent any supplementation is required to provide coverage within each EHB category. The scope of benefits cannot exceed the generosity of the most generous among a set of comparison plans, including the state's EHB benchmark plan used for the 2017 plan year, and any of the state's base-benchmark plan options for the 2017 plan year. The federal deadline to select a new EHB benchmark plan for the 2022 plan year is May 8, 2020. The rule also requires the state to provide reasonable public notice and an opportunity for public comment on the state's selection of an EHB benchmark plan. It is at a state's option to review its EHB benchmark. California is not obligated to change its benchmark under these rules.