Health Care Reform: Get Informed

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The Affordable Care Act: An Overview

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Health Care Reform: Get Informed

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About the Coalition

• Nonpartisan alliance of individuals and 87 state-wide organizations

• National Partners
  – Raising Women’s Voices
  – Open Society Institute-Baltimore
  – National Women’s Law Center
Coalition Mission

Work collaboratively with our members and partners to seek solutions and advance reforms to **ensure** that every resident of Maryland has access to **affordable, comprehensive & high quality health care** that is always there.
Maryland: A National Leader

- Commitment and Leadership
- Effective Process:
  - Health Care Reform Coordinating Council;
  - Office of Health Care Reform; &
  - Health Benefit Exchange Board
- Roadmap
Maryland Health Connection:
A Health Insurance Supermarket

• Exchange will describe each plan in a standard format
  – Monthly cost and co-pays
  – Plan performance on quality measures
  – Plan ratings by quality and price

• Compare Apples to Apples

• Can’t decide between a Fuji and a Rome? Get help!
  – Website
  – Telephone hotline
  – Navigators
Health Benefit Exchange Timeline

Landmark ACA Legislation signed into Law 3/23/2010 by President Obama

4/12/2011
Governor O’Malley
Signed Health Benefit Exchange Act into Law

6/3/2011
Exchange Board 1st Meeting

9-11/2011
Advisory Committees Met

1/1/2013
Exchange Must be Certified by Federal Government

10/1/2013
Individuals and Groups Begin Enrolling in Exchange

1/1/2014
Maryland Health Benefit Exchange will be Operational

Source: A Report to the Governor and Maryland General Assembly
Maryland Health Benefit Exchange, December 23, 2011, p. 1

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Maryland’s Health Benefit Exchange

• Public corporation/independent unit of state government
• 9-member board
• 7 Principles
  – Access
  – Affordability
  – Sustainability
  – Stability
  – Health Equity
  – Flexibility
  – Transparency

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Creating the Exchange: Stakeholder Input

Exchange Advisory Committees
• Navigator
• Continuity of Care
• Plan Management
• Exchange Implementation

OHCR Advisory Committees
• Essential Health Benefits
• Finance & Sustainability
• Communications
Creating the Exchange: Stakeholder Representation

Advisory Committee Membership by Affiliation

- Health Insurance Industry: 34%
- Community Care Providers and Associations: 18%
- Community Members and Advocates: 21%
- Academia: 12%
- Business Owners: 9%
- Local Government: 3%
- Consultants: 3%

Source: A Report to the Governor and Maryland General Assembly, Maryland Health Benefit Exchange December 23, 2011, p. 2

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Key Decisions To Date

• Essential Health Benefit
• Plan Management
  – Carrier Certification for Qualified Health Plans (QHP)
  – Essential Community Providers
  – Network Adequacy
• Navigator Program
MARYLAND
ESSENTIAL HEALTH BENEFITS
FOCUS: BEHAVIORAL HEALTH
THE EHB REQUIREMENTS UNDER THE ACA

- The Affordable Care Act establishes the basic requirements for the Essential Health Benefit package

  - Must include 10 categories of benefits, balanced among the categories:
    * mental health and substance use disorder treatment (MH/SUD)
    * ambulatory services
    * emergency services
    * in-patient hospital services
    * maternity and newborn care
    * prescription drugs
    * rehabilitative and habilitative services
    * laboratory services
    * preventive and wellness services, and chronic disease management
    * pediatric, including oral and vision

  - Must be offered by ALL plans in the individual and small group market (also Medicaid and BHP)

  - Must be defined by the Secretary of Health and Human Services to equal scope of benefits under typical employer plan and defined in a way that does not discriminate based on age, disability or expected length of life.
**December 16, 2011 HHS Essential Health Benefits Bulletin**
- *States to choose benchmark:* HHS directs states to choose a benchmark from 10 options
  - *Plan flexibility:* plans may offer benefits that are “substantially equal.” Flexibility standard will be similar to equivalency standard under Medicaid CHIP.
- *The Federal parity law:* parity applies to EHB

**February 17, 2012 Frequently Asked Questions**
- *Reiterated:* “Consistent with Congressional intent, we intend to propose that the parity requirements apply in the context of the EHB.”
- *Medicaid may select different Benchmark plan*

**Informal guidance:** No substitutions for MH/SUD from other plans simply because MH/SUD is not parity compliant

EHB *Parity compliance* does not require identification of non-quantitative treatment limitations attached to a benefit.
• The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires:

  *MH/SUD treatment limitations* (e.g. number of visits, days of coverage) and *financial requirements* (e.g. deductibles/co-pays) can be no more restrictive than those limitations or requirements applied to medical surgical benefits;

  *MH/SUD medical management standards* - “*non-quantitative treatment limitations*” - (e.g. prior authorizations, fail-first requirements, medical necessity, network adequacy) must be comparable to and applied no more stringently than medical surgical standards

• Federal parity law **does not** require that a plan provide MH/SUD benefits, but if plans offer MH/SUD – and in 2014 all EHB plans must include MH/SUD -- the benefits must be comparable to those for physical illnesses.

• Federal parity **does not** require plans to expand range of conditions/disorders covered.
• ACA extends MHPAEA
  *Individual EHB Plans*: extends MHPAEA to individual plans in and out of Exchange

  *Small Group plans in the Exchange*: applies parity requirements to all QHPs “in the same manner and the same extent that such requirements apply to health insurance issuers and group health plans.” ACA Section 1311(j)

• Parity for Small Group Plans Outside the Exchange. Question has arisen re application of parity to small group employee plans outside the Exchange. Although not explicit in ACA, indications from individuals involved in drafting suggest strongly that intent was to include all EHB plans, including small employer outside of Exchange. This is confirmed in the HHS EHB guidance that provides that parity applies to EHB Plans in 2014.

• Parity at the EHB Level: No cost-sharing analysis. Benefit identification does not include non-quantitative treatment limitations

• Parity at the Plan Level. MD Health Benefit Exchange Act establishes that one of the criteria to be used for certification of Qualified Health Plans is demonstration of compliance with MHPAEA
  - Plans would need to prove that cost-sharing, medical management policies and procedures, or authorization requirements for MH/SUD are not more restrictive
- **Health Care Reform Coordinating Council (HCRCC).** Maryland Health Benefit Exchange Act of 2012 authorized the HCRCC, a bipartisan legislative/executive body, to select the benchmark.

- **Selecting the best Option for MH/SUD consumers:**
  * federal GEHA plan the most robust package (included SUD residential/not MH residential)
  * State Employee plans appeared to offer full continuum; but not clear if offer residential
  * small group plan included limitations, **not MHPAEA compliant**.

- **Strong Consumer Advocacy and Participation:** Importance of education and advocacy on Mental Health and Substance Use Disorder (MH/SUD) treatment benefits and issues, especially relating to MHPAEA.

- **State selection:** State Employee PPO plan
CHALLENGES IN OPERATIONALIZING THE EHB

- Lack of guidance from HHS
- Identifying Parameters for Plan Flexibility
- Achieving specificity in defining MH/SUD benefits
- Applying Parity to the EHB
PLAN FLEXIBILITY

• **Why Flexibility?** According to HHS: to “provide greater choice for consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHB offer a certain level of benefits”
  (EHB Bulletin 12/16/2011, p. 12)

• **Parameters for flexibility** (EHB Bulletin, p. 12):

  * Medicaid CHIP: actuarial equivalency for mental health benefit category substitutions must equal 75% of the costs of benchmark services in that category
    * includes both the services covered and any quantitative limits
    * “subject to a certain baseline set of relevant benefits”

**Informal Guidance:** HHS has stated that it will allow States to define flexibility
• **Parity.** Ensure that Parity applies notwithstanding flexibility standard.

• **Incorporate Parity Regulations.** Include as part of the EHB definition or operationalization standard an explicit requirement that the EHB must comply with MHPAEA and all regulations issued thereunder.

• **Baseline Benefits.** As referenced under the EMB Bulletin, establish a “baseline set of relevant benefits.” that includes the full continuum of care for MH/SUD

• **Protect Mandated Benefits.** Ensure that flexibility does not permit change to mandated benefits
Accessing Behavioral Health Treatment in the Health Benefit Exchange

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The Exchange: Removing Barriers to Accessing Treatment

- Qualified Health Plans
  - All plans are required to cover the EHB, but the plans may have differing cost sharing or utilization review requirements.
  - Plans will be certified by the Exchange and may have to meet higher standards in some areas than plans sold in the outside market.
  - Must be complaint with federal parity law
  - Network Adequacy Standards
  - Continuity of Care Requirements
Adequate Provider Networks

- Qualified Health Plans must ensure that there is an adequate number of mh/sud providers in each network
  - These providers were specifically mentioned in the Affordable Care Act
- Qualified Health Plans must contract with Essential Community Providers in adequate numbers to serve medically underserved populations
  - The Exchange will be collecting data and preparing a quarterly report on these two issues.
Maryland will expand Medicaid eligibility to 138%, but individuals who reach 139+% will become eligible for subsidies in the Exchange and will transition to the private market.

Medicaid benefits are likely to be much richer, especially for behavioral health than what is offered in the Exchange plans.

The Exchange is undertaking a process to determine what requirements should be in place to help these individuals make smooth transitions without delays in care or being forced into redundant care.

This process began in September and will continue through December 2012.
Remaining Challenges and Concerns

- Ensuring Parity Compliance for EHB and Qualified Health Plans
  - Individual and small group plans were previously exempt
- Network Adequacy Issues
  - Pent-up demand
  - New population
- Adequate Continuity of Care Provisions
- Appropriate Education and Outreach Activities
Resources You Can Use

• **Maryland**
  – Health Benefit Exchange
    [www.dhmh.maryland.gov/healthreform/exchange](http://www.dhmh.maryland.gov/healthreform/exchange)
  – Department of Health & Mental Hygiene
    [www.dhmh.maryland.gov](http://www.dhmh.maryland.gov)
  – Maryland Health Connection
    [www.marylandhealthconnection.gov](http://www.marylandhealthconnection.gov)
  – Health Care Reform Coordinating Council
    [www.healthreform.maryland.gov](http://www.healthreform.maryland.gov)

• **Federal**
  – Department of Health & Human Services
    [www.healthcare.gov](http://www.healthcare.gov)
Stay Informed & Get Involved

- Join the Coalition
  - Newsletters, Alerts, Member Calls & Webinars
  - Educational forums:
  - Facebook and Twitter
- Encourage others to join
- Share your stories

www.mdhealthcarereform.org
Contact Information

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