Defining Essential Health Benefits For Delaware

Contents

INTRODUCTION **2**

Essential Health Benefit Requirements 3

The "Benchmark" Approach 3

Effect on Current Health Plans 4

Effect on State Mandates 4

Updating the Benchmark 5

Coordination with Medicaid Benefits 5

U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) A AND B RECOMMENDATIONS **6**

DELAWARE MANDATED BENEFITS **10**

DELAWARE MEDICAID SERVICES **11**

BENCHMARK OPTIONS FOR DELAWARE **14**

Small Group Plan Options 14

State Employee Plan Options 15

Federal Employee Plan Options 15

Additional Considerations 16

INSTRUCTIONS **17**

Introduction

The purpose of this document is to provide the State of Delaware with information about the available benchmarks for the essential health benefits package. The essential health benefits, known as EHBs, will be the baseline package of services that **all health insurance plans in the individual and small group markets** will be required to cover. Any services that are included in the EHB package will be offered without annual or lifetime dollar limits to all members. The "benchmark" for coverage in 2014 and 2015 will be the services covered by a plan that is currently offered in Delaware.

Some Delaware small businesses offer their employees self insured plans. Self insured plans are not required to cover all of these EHB services. Notably, self-insured plans will not be allowed to apply annual or lifetime dollar limits on the EHBs they do cover. Therefore, it is important that all consumers, employees, and employers participate in the EHB selection process.

Several parts of a typical benefit description are not considered in selecting essential health benefits. Limits on the number of services a person may receive in a year are included; cost sharing requirements are not included. For example, the essential health benefits package **may include** the following:

- Service X is limited to 30 visits per year, and the plan must pre-approve the service.

The essential health benefits **may NOT include** information such as:

- Service X requires the member to pay a 30% of the cost out of pocket.

The insurance carriers will also be able to use mixes of benefits that are "substantially equivalent" to the selected benchmark plan as long as the services that they offer have the same total value as the benchmark services. For example, the benchmark might cover 30 physical therapy visits and 20 occupational therapy visits per year. An insurance carrier might design a plan that covers 20 physical therapy visits and 30 occupational therapy visits per year and be considered "substantially equivalent" to the EHB benchmark.

Essential Health Benefit Requirements

- All health plans offered to individuals and small groups (except self insured plans) are required to cover these 10 service categories:

    1. Ambulatory patient services;
    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 oral and vision care.

- Standalone dental plan coverage (meaning dental plans that are sold separately from other types of health coverage) can be used to cover the pediatric oral services requirement.
- All plans must at least cover the U.S. Preventive Services Task Force Schedule A and B benefits without cost sharing. A list of those services is included in this packet.

The "Benchmark" Approach

- Each State may choose its own benchmark plan from these options:
    - One of the three largest small group plans in the State by enrollment;
    - One of the three largest State employee health plans by enrollment;
    - One of the three largest federal employee health plan options by enrollment; and
    - The largest HMO plan offered in the State's commercial market by enrollment.
- Since many of these benchmark options do not cover all required EHB categories, the benchmark that is chosen may be supplemented by coverage from another benchmark.
    - For pediatric oral services, the available benchmarks include:

        - Delaware Healthy Children (CHIP) dental benefits
        - Federal Employees Dental and Vision Insurance Program (FEDVIP) dental benefits
    - For pediatric vision services, the FEDVIP vision benefits may be used as a supplement

- The federal government issued guidance on December 16, 2011 that made many important points in addition to specifying guidance on how states must choose the essential health benefits of their Exchange.
    - Department of Labor surveys showed that there are not many differences among the benchmark options for major categories like physician services, surgeries and procedures, inpatient and outpatient hospital, routine lab tests and prescription drug coverage.
        - However, these services do have differences in their cost sharing requirements.

Effect on Current Health Plans

- All plans in the individual and small group markets will be required to offer benefits that are "substantially equal" to the benchmark plan.
    - Plans will be able to adjust the specific services that are included as part of the benefit, and any quantitative limits on certain services (for example, number of visits per year), as long as the coverage has the same *value* as the benchmark plan.

Effect on State Mandates

- All states have a set of services that the State requires certain insurance plans to cover. These services are called "mandates."
- If the EHB benchmark does not include all of the State mandates, then the State will be required to pay for the portion of insurance premiums associated with those mandates for all plans sold in the Health Insurance Exchange.
- All small group plans and State Employee plans in Delaware cover the state mandates that apply to the small group market and were passed before December 2011.
- A list of state mandates passed before December 2011 is included in this packet.

Updating the Benchmark

- The benchmark that is chosen now will be the benchmark for coverage in 2014 and 2015, but may change in 2016 and beyond.

Coordination with Medicaid Benefits

- Many low-income Delaware families will qualify for Medicaid or Health Insurance Exchange subsidies to help them pay for coverage.
- Because both Medicaid and subsidy eligibility can be based on the family's income, a number of families may qualify for different benefits at different times.
- When selecting a benchmark plan, Delawareans may want to consider how the Medicaid benefits in the State compare to the benchmark benefits. A list of current Medicaid benefits is included in this packet.

U.S. Preventive Services Task Force (USPSTF) A and B Recommendations

Topic	Description	Grade
Abdominal aortic aneurysm screening: men	One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.	B
Alcohol misuse counseling	Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.	B
Anemia screening: pregnant women	Routine screening for iron deficiency anemia in asymptomatic pregnant women.	B
Aspirin to prevent CVD: men	Use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A
Aspirin to prevent CVD: women	Use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A
Bacteriuria screening: pregnant women	Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A
Blood pressure screening in adults	Screening for high blood pressure in adults aged 18 and older.	A
BRCA screening, counseling about	Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes should be referred for genetic counseling and evaluation for BRCA testing.	B
Breast cancer preventive medication	Clinicians should discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.	B
Breast cancer screening	Screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.	B
Breastfeeding counseling	Interventions during pregnancy and after birth to promote and support breastfeeding.	B
Cervical cancer screening	Screening for cervical cancer in women who have been sexually active.	A

Topic	Description	Grade
Chlamydial infection screening: non-pregnant women	Screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.	A
Chlamydial infection screening: pregnant women	Screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.	B
Cholesterol abnormalities screening: men 35 and older	Screening men aged 35 and older for lipid disorders.	A
Cholesterol abnormalities screening: men younger than 35	Screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.	B
Cholesterol abnormalities screening: women 45 and older	Screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.	A
Cholesterol abnormalities screening: women younger than 45	Screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.	B
Colorectal cancer screening	Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A
Dental caries chemoprevention: preschool children	Primary care clinicians should prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.	B
Depression screening: adolescents	Screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B
Depression screening: adults	Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B
Diabetes screening	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B
Folic acid supplementation	All women planning or capable of pregnancy should take a daily supplement containing	A

Topic	Description	Grade
	0.4 to 0.8 mg (400 to 800 µg) of folic acid.	
Gonorrhea prophylactic medication: newborns	Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.	A
Gonorrhea screening: women	Clinicians should screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B
Healthy diet counseling	Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B
Hearing loss screening: newborns	Screening for hearing loss in all newborn infants.	B
Hemoglobinopathies screening: newborns	Screening for sickle cell disease in newborns.	A
Hepatitis B screening: pregnant women	Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A
HIV screening	Clinicians should screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.	A
Hypothyrodism screening: newborns	Screening for congenital hypothyroidism in newborns.	A
Iron supplementation in children	Routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.	B
Obesity screening and counseling: adults	Clinicians should screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.	B
Obesity screening and counseling: children	Clinicians should screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B
Osteoporosis screening: women	Women aged 65 and older should be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.	B

Topic	Description	Grade
PKU screening: newborns	Screening for phenylketonuria (PKU) in newborns.	A
Rh incompatibility screening: first pregnancy visit	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A
Rh incompatibility screening: 24-28 weeks gestation	Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B
STIs counseling	High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.	B
Tobacco use counseling and interventions: non-pregnant adults	Clinicians should ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A
Tobacco use counseling: pregnant women	Clinicians should ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A
Syphilis screening: non-pregnant persons	Clinicians should screen persons at increased risk for syphilis infection.	A
Syphilis screening: pregnant women	Clinicians should screen all pregnant women for syphilis infection.	A
Visual acuity screening in children	Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.	B

* The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force.

Delaware Mandated Benefits

- Care for Newborn Children
- Newborn and Infant Hearing Screening
- Child Immunizations
- Lead Poisoning Screening
- Obstetrical and Gynecological Coverage
- Midwife Services Reimbursement
- Reconstructive Surgery following Mastectomies
- Monitoring ovarian cancer following treatment
- Pap smear
- Mammography
- PSA: Policies that provide outpatient services must provide benefits for persons over 50
- Colorectal Screening
- Diabetes
- Contraceptive Drugs and Devices
- Mental Health Parity
- Clinical Trials: Routine patient care for individuals engaged in clinical trials for treatment of life threatening diseases
- Prescription Medication
- Emergency Care
- Referrals to out-of-network providers under certain circumstances
- Carrier may not limit coverage for children who are victims of child abuse or neglect, must not require PCP referral
- Coverage of dependents up to age 24
- Formulas and foods for the treatment of inherited metabolic diseases such as PKU
- Scalp hair prosthesis for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease
- Hearing aids for individuals under age 24
- Dental services for children with severe disabilities
- Screening of infants and toddlers
- Prosthetic Parity

Delaware Medicaid Services

Medicaid Benefits	Limits
Allergy Testing	
Ambulance (air and ground)	
Behavioral Health and Substance Abuse counseling (children)	
Behavioral Health and Substance Abuse counseling (adults)	
Blood and plasma products	
Bone Density X-Ray	
Cancer Screenings	
Cancer Testing and Treatment (including radiation, chemotherapy, and surgery)	
Childbirth Education	
Colorectal Screening Exam	
CT Scans	
Dental Services (under age 21)	
Diabetes care (including education, podiatry care, equipment, and supplies)	
Dialysis	
Prescription drugs	
Durable Medical Equipment	
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) (Well child checkups and screenings for children under age 21)	
Emergency Room Care	
Eye exams necessary to treat eye infections, diabetes, or glaucoma	
Routine eye exams every 12 months, including eyeglasses, contacts (under age 21)	
Family planning (including lab tests, birth control, voluntary sterilization, and office visits)	
Genetic testing to determine presence of disease	

Medicaid Benefits	Limits
Glaucoma screening	
Gynecology visits	
Hearing aids and batteries (under age 21)	
Hearing exams	
HIV/AIDS and STD testing	
Home Health Care and Aid services	
Hospice Care	
Hospital Services (inpatient and outpatient)	
Immunizations	
Infusion therapy	
Laboratory services	
Mammogram	
Medical Supplies	
MRA	
MRI	
Nutritional Counseling	
Obstetrical/Maternity Care (Women who are pregnant, and 90 days following birth of child)	
Orthopedic Shoes and Inserts	
Outpatient Surgery, Same Day Surgery, Ambulatory Surgical Center	
Pain management services for long term or chronic pain	
PET Scan	
Yearly physicals	
Podiatry Care	
Primary Care Services	
Private Duty Nursing	
Prostate Cancer Screening	
Prosthetics and Orthotics	
Rehabilitation (Inpatient)	
Skilled Nursing Facility	

Medicaid Benefits	Limits
Sleep Apnea Studies	
Specialist Services	
Outpatient Physical, Occupational, and Speech Therapy	
Transportation, non-emergent	
Urgent Care Centers	
Well woman services	
X-Rays	
Case Management	
Disease Management	

Benchmark Options for Delaware

Small Group Plans

1. Blue Cross Blue Shield (BCBS) Exclusive Provider Organization (EPO);
2. Blue Cross Blue Shield (BCBS) Health Maintenance Organization (HMO); and
3. Coventry Point of Service (POS).

State Employee Plans

1. Comprehensive Preferred Provider Organization (PPO);
2. HMO; and
3. Consumer Directed Health (CDH) Gold.

Federal Employee Plans

1. Blue Cross/Blue Shield FEHP Standard Option;
2. Blue Cross/Blue Shield FEHP Basic Option; and
3. Government Employees Health Association (GEHA) Plan.

(The largest HMO plan in Delaware is also the State Employee HMO plan, so there are only nine options rather than 10)

Small Group Plan Options

Blue Cross/Blue Shield – Differences between HMO and EPO options:

- HMO plan offers limited coverage of artificial insemination services (not covered by the EPO plan).
- HMO does not specify quantitative limits on hospice care, which is limited to 240 days under the EPO plan.
- HMO plan also includes provider restrictions for certain benefits. For example, allergy testing is only covered when performed by the member's primary care provider (PCP) or a referred specialist.

Differences between Coventry and Blue Cross/Blue Shield:

- Coventry skilled nursing facility coverage is limited to 100 days, rather than 120 days.

- Coventry includes broader coverage of infertility services, and also voluntary sterilization services.
- Therapy limits are defined differently; Coventry covers services up to 60 days from date on onset, while BCBS covers 30 visits per calendar year.
- Coventry includes respiratory rehabilitation among their rehab services.
- Coventry covers ten podiatry service visits per benefit year.
- Chiropractic care is covered for 20 visits per benefit year under Coventry versus 30 visits per calendar year under BCBS.
- Coventry prescription drug coverage is only available through purchase of an additional rider.
- Coventry limits mental health coverage to the treatment of "serious mental illness and substance abuse". BCBS offers additional, limited coverage for other mental health disorders that do not meet the definition of "serious" mental illness.
- BCBS covers home infusion and inpatient private nursing duty services, which are not included in Coventry's schedule of benefits.

State Employee Plan Options

Among the State Employee Plan Options, benefit differences are very limited.

- Chiropractic care is limited to 60 consecutive days under the HMO plan versus 30 visits per calendar year under the PPO and CDH Gold plans.
- The HMO plan limits physical therapy to 45 visits per condition and speech therapy to 60 days from onset of therapy. The PPO and CDH Gold plans do not quantitatively limit these services.
- The HMO plan covers a second surgical opinion, while the PPO and CDH Gold plans do not include this option in the schedule of benefits.

Note that prescription drug coverage is administered separately for the State Employee plans and will need to be supplemented by a different benchmark option.

Federal Employee Plan Options

- The maternity benefit under BCBS is substantial, including post partum care and mental health treatment for post partum depression. GEHA does not include these services in their schedule of benefits.

- BCBS Standard Option only covers skilled nursing facility (SNF) care as a supplement to Medicare Part A coverage, while the Basic Option does not cover this service at all. GEHA covers SNF for 14 days following release from an acute care hospital setting.
- Physical and occupational therapy are limited to 75 visits under BCBS Standard, 50 visits under BCBS Basic, and 60 visits under GEHA.
- Speech Therapy is limited to 75 visits under BCBS Standard, 50 visits under BCBS Basic, and 30 visits under GEHA per calendar year.
- Cognitive therapy is only covered by BCBS.
- Chiropractic care is covered for 12 visits under BCBS Standard and GEHA and 20 visits under BCBS Basic per calendar year.
- Home health is limited to 25 days per year under BCBS versus 50 days per year under GEHA.

Additional Considerations

1. Because the small group plans have slightly fewer optional benefits than the federal or state plans, somewhat lower premium costs are likely to result. However, it is important to note that, for Delaware, the small group plan options have higher quantitative limits on chiropractic care and significantly stronger skilled nursing facility and home health benefits than the Federal Employee plans.

2. For Delaware, the Federal Employees plan offers higher quantitative limits on most therapy benefits, a more robust maternity care benefit that includes post partum treatment and behavioral health services for post partum depression, acupuncture coverage, and broader mental health coverage. However, coverage for services such as skilled nursing facility (SNF) care, home health, and hospice are significantly limited under the Federal plan options.

Instructions

Please review all of the benchmark option materials and let the State know your opinion! The benchmark plan materials can be found under What's New on the Delaware Health Care Commission website http://dhss.delaware.gov/dhss/dhcc. What should the State consider in choosing from these benchmark options? Please submit written comments to the Health Care Commission before August 2, 2012.

By email: HBE_Delaware@state.de.us (HBE_Delaware@state.de.us)

By mail: Delaware Health Care Commission
Margaret O'Neill Building, Third Floor
410 Federal Street - Suite 7
Dover, DE 19901
Telephone: (302) 739-2730
FAX: (302) 739-6927

A statewide forum will be held **June 27, 2012 from 6-8pm** for the State to hear initial comments and address any questions or need for clarification on the options.

A second forum will be held **July 17, 2012 from 6-8pm** during which the State will summarize the comments received to date and hear additional feedback from the public.

Both forums will be held at the DelTech Terry Campus (address below):

DelTech Terry Campus
100 Campus Drive
Dover, DE 19904
Corporate Training Center
Rooms 400 A&B

All final comments must be received by **August 2, 2012**.

REMEMBER:

- Plans that do not have limits on the number of visits or services that a member may receive usually require that the member pay copayments or deductibles for those services. The essential health benefits benchmark will not prevent plans from requiring cost sharing on services.
- All small group plans and state employee plans cover all Delaware State mandates that were passed before December 2011.
- All plans must cover U.S. Preventive Services Task Force Schedule A and B benefits without cost sharing.
- Benchmark plans that cover more services will have higher premiums than those with fewer services.