



Implementing the Essential Health Benefits Requirement in New Jersey: Decision Points and Policy Issues

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I. Executive Summary

The Affordable Care Act (“ACA”) is designed to expand and improve health insurance coverage for American consumers. It is a complex law, expanding eligibility for public insurance, providing subsidies for private insurance, and reforming the content of insurance in many ways. One significant reform to the content of insurance is the requirement that most individual and small group insurance policies, beginning in 2014, guarantee coverage of a slate of ten “essential health benefits” (“EHB”):

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.

Some of these categories of covered services are familiar to most existing coverage; it is rare to find a health insurance product that does not cover hospitalization and emergency services. Others are increasingly common, including prescription drugs and preventive care. Others are poorly covered or absent in some existing private insurance, including mental health and habilitative services.

Delineation of these categories of services is intended to assure consumers and small businesses purchasing coverage after 2014 that the coverage will be comprehensive, providing key services at appropriate levels to address serious health conditions. Listing the categories of

services was only the beginning of providing that assurance, however. The process by which the EHB requirements have been and will be fleshed out, and the means by which the requirement will be monitored and enforced, will require substantial attention at the federal and state levels. This Issue Brief describes the statutory content of the EHB requirement, the federal regulatory process that is adding specificity to the requirement, and New Jersey's substantial role in the regulatory process. The Brief has several points of emphasis.

What Is “Essential”?

At the core of the EHB requirement is the conviction that the content of insurance coverage matters. It is fundamental that a person's ownership of an insurance card is only as valuable as the services to which that card creates an entitlement. Elsewhere in the ACA, Congress announced minimum requirements for health insurance coverage, addressing for example lifetime and annual dollar limits and preexisting illness exclusions. With the EHB requirement, Congress was more fine-grained, requiring that most individual and small group health insurance uniformly cover services comprising a comprehensive menu of health care. That is, Congress determined that health insurance, to be worthy of the name, should cover each of the ten categories of essential health benefits.

Much of the detail of what must be covered was left to the regulatory process. What pharmaceuticals, for example, must be covered by insurance for it to satisfy the EHB requirement? The details are important, although uncertainty is more likely to arise in some areas than others. Hospitalization has been a staple of health insurance since its inception, and coverage rules are relatively well-established. The rules for pharmaceutical coverage are more varied, those for mental health coverage are quite disparate, and those for habilitative care are practically nonexistent. To which drugs will a cancer patient be entitled? What services must be covered for a person with multiple sclerosis? For what adjunctive therapies will families with children on the autism spectrum disorder have coverage? The regulatory process will struggle to provide clarity on these and similar questions.

The Process for Defining What Is Essential

Regulatory responsibility for the EHB requirement was placed in the first instance with the Secretary of the Department of Health and Human Services. As background preparation, several public and private entities undertook research to understand the existing coverage landscape, and provided the results to the Secretary. She was charged with a difficult task. The ACA clearly required that the listed essential benefits be available to insured persons. The law also provided some interpretive principles. Coverage decisions must not weight coverage of some categories at the expense of others; plan design must take into account the needs of diverse and vulnerable subpopulations; and coverage design must avoid discriminating against people on

the basis of the degree of their illness or disability. In addition, and to reflect the ACA's mandate that the Secretary balance comprehensiveness of coverage with the goal of cost containment, it required that the Secretary be guided by the content of existing employer coverage. This last principle may present the greatest challenge, as it requires the Secretary to balance robust coverage goals with cost containment imperatives.

Many expected the Secretary to provide definitions, in some detail, of the content of the requirement in each of the ten categories. The Secretary has instead provided an intended regulatory approach for the years 2014-2015. She has indicated an intent to devolve much of the responsibility to the states, empowering the states to adopt a "benchmark" plan as the model for complying coverage. The benchmark plan is to be selected from among the popular products in the small employer market, the commercial HMO market, the state's employee health benefits plans, and the federal employee benefits plans. The chosen plan must be supplemented where it does not adequately cover any of the ten coverage categories. The plan, as supplemented, becomes the state's benchmark plan. Individual and small group carriers must be guided by the benefits design of the benchmark plan, although they may modify the coverage to some extent within still-developing constraints, including the requirement that the modified coverage be substantially equal and actuarially equivalent to that of the benchmark plan. The Secretary has promised more detailed descriptions of the process by which supplementation and modification will be evaluated.

New Jersey's Role Is Substantial

The Secretary's intended devolution of regulatory power to the states leaves New Jersey with an important EHB role. New Jersey is empowered to select a benchmark plan, a decision which must be made by September 2012; should New Jersey not select a benchmark plan, one will be selected by the Secretary. As is described in this Brief, federal guidance and state law complicate the question of which official or office within New Jersey is empowered to make that designation, and by what process. The decision will be consequential in several ways. For example, the Secretary's decision to phase in state responsibility for covering the costs of state-mandated benefits beyond those required under the ACA's EHB provisions highlights the importance of evaluating the content of the proposed benchmark plans. The selection and modification of a particular plan may save the State from responsibility for the cost of some mandated benefits for an interim time period. More fundamentally, New Jersey has the opportunity to balance coverage and cost, protect the interests of vulnerable populations, and ensure that no category of coverage receives short shrift in New Jersey's benchmark plan. Consumers and other stakeholders can play an important role as this choice is made.

The monitoring and enforcement of the EHB provisions will be a shared responsibility, and New Jersey's role can be substantial. As plans conform to ACA requirements, and as additional consumers gain coverage, disputes will arise over whether a product is complying

with its responsibilities to cover essential health benefits. New Jersey has in place requirements for some internal and external appeals of coverage decisions. But systemic review, triggered by complaints, appeals, or routine evaluations, will also be important. The Department of Banking and Insurance, the State's health insurance Exchange board (if and when one is created), and formal and informal advisory groups can protect consumers by reviewing consumer experience and responding to any shortfalls in the coverage of essential benefits.

This Brief sets out the statutory and regulatory background that guides the State as the EHB process develops. The manner in which the ACA and federal guidance are interpreted by the State and by insurance carriers can assure consumer access to services essential to their health and well-being.

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II. Federal Essential Health Benefits Statutory Provisions

An important feature of the Affordable Care Act (“ACA”) is its establishment of minimum coverage requirements for many categories of health insurance. Beginning in 2014, Section 2707 of the Public Health Service Act (“PHSA”), as added by Section 1201 of the ACA, requires health insurance plans offered in the individual and small group markets, both in and out of a health insurance Exchange, to include health insurance coverage that contains, at minimum, a package of benefits referred to as essential health benefits (“EHB”).¹ Plans wishing to be deemed qualified health plans (“QHPs”) that may be offered through state Exchanges must offer coverage of EHB.² The EHB requirement does not apply to self-insured group, large group,³ or grandfathered⁴ health plans.⁵

¹ See 42 U.S.C. § 300gg-6(a). The essential health benefits package defined in the ACA also includes limits on cost-sharing, such as deductibles, co-insurance, and co-payments, and identifies different levels of coverage, *see id.* § 18022(a)(2) & (3), but the details of those provisions are beyond the scope of this Issue Brief. *See generally* Actuarial Value and Cost-Sharing Reductions Bulletin (Feb. 24, 2012), <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>. The ACA defines the small group market as including employers with an average of 1-100 employees, at least one of whom was employed on the first day of the plan year, *see* 42 U.S.C. §§ 300gg-91(e)(4) & (5), 18024(b)(2), although it also permits States to substitute 50 for 100 in the small group definition until 2016, *see id.* § 18024(b)(3); *see also* 45 C.F.R. § 156.120 (adopting meaning of small group used in 45 C.F.R. § 155.20, which adopts meaning in Section 1304(a)(3) of the ACA, which is codified at 42 U.S.C. § 18024, for the purpose of collecting data to help define EHB).

² See 42 U.S.C. § 18021(a)(1)(B). Beginning January 1, 2014, EHB requirements also will apply if a state chooses to create a basic health program for low income individuals, *see id.* § 18051(a)(1), and to Medicaid benchmark or benchmark equivalent plans, *id.* § 1396u-7(b)(5). *See* Center for Consumer Info. & Ins. Oversight, Essential Health Benefits Bulletin, at 6-7 (Dec. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf [hereinafter Bulletin]. This Issue Brief, however, focuses on EHB for non-BHP and non-Medicaid plans.

³ But in states that exercise their option to permit issuers to offer qualified large group coverage through the state’s Exchange beginning in 2017, *see* 42 U.S.C. § 18032(f)(2)(B), EHB will apply to large group QHPs sold through these Exchanges. *See* Stacey A. Tovino, A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits, 38 A. J. Law & Med. 471, 479 (2012).

⁴ The ACA exempts or “grandfathers” plans that existed on March 23, 2010, when the statute was signed, from many of its provisions, including essential health benefits. *See* 42 U.S.C. § 18011; Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient

The statute charges the Secretary of the United States Department of Health and Human Services (“HHS”) with the task of defining EHB, subject to certain statutory limitations and requirements.⁶ EHB shall include at least ten “general categories and the items and services covered within the categories,” namely:

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;⁷
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.⁸

This general requirement is subject to an important statutory caveat: the Secretary must ensure that the scope of EHB “is equal to the scope of benefits provided under a typical

Protection and Affordable Care Act, 75 Fed. Reg. 34,538-70 (June 17, 2010) (to be codified at 26 C.F.R. pts. 54 and 602, 29 C.F.R. pt. 2590, and 45 .C.F.R. pt. 147); *see generally* Mark Merlis, *Health Policy Brief: ‘Grandfathered’ Health Plans*, HEALTH AFFAIRS (Oct. 29, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=29 (last visited July 26, 2012).

⁵ *See* Dep’t of Health & Human Servcs., Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Essential Health Benefits Bulletin*, at 4 (Feb. 17, 2012), <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf> [hereinafter FAQ]. Self-insured, large group, and grandfathered plans are prohibited, however, by Section 2711 of the PHSa from imposing annual and lifetime dollar limits on EHB. *Id.* Thus, while these plans are not required to offer EHB, to the extent they do, they may not impose dollar limits on these benefits. They may, however, impose non-dollar limits on EHB and annual and lifetime dollar limits on benefits that exceed EHB. *Id.* It would seem to be within the regulatory responsibilities of the New Jersey Department of Banking and Insurance (“DOBI”) to monitor grandfathered and large group plans in New Jersey to ensure compliance with these restrictions. *See infra* Section V.E. for a discussion of the importance of monitoring and enforcement.

⁶ *See* 42 U.S.C. § 18022(b).

⁷ HHS intends to propose that mental health parity, as required by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), applies to plans that must offer EHB. *See* Bulletin, *supra* note 2, at 8, 12; FAQ, *supra* note 5, at 5; *see also* 42 U.S.C. § 18031(j) (extending mental health parity requirements from Section 2726 of the PHSa to QHPs); *see generally* Amanda K. Sarata, Congressional Research Service, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, 7-5700, R41249 (Dec. 28, 2011) (reviewing ACA’s expansion of federal mental health parity requirements to QHPs, Medicaid non-managed care benchmark and benchmark-equivalent plans, and plans offered through the individual market but noting that some small employer plans seem to continue to be exempt from parity requirements under existing small employer exemptions), <http://www.ncsl.org/documents/health/MHparity&mandates.pdf>.

⁸ 42 U.S.C. § 18022(b)(1)(A)-(J).

employer plan, as determined by the Secretary.”⁹ The ACA requires the Secretary of Labor to assist the Secretary of HHS in making this determination by preparing a report of “a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans”¹⁰

The ACA also tasks the Secretary with several obligations in defining EHB. Importantly, EHB must “reflect an appropriate balance among” the ten itemized categories “so that benefits are not unduly weighted toward any category.”¹¹ The Secretary also may not “make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.”¹² The definition of EHB also must “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.”¹³ In addition, health benefits deemed essential may not be denied “on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.”¹⁴ A modified definition of EHB applies to catastrophic plans offered in the individual market.¹⁵

The statute also itemizes EHB provisions that apply only to QHPs, including requirements for QHPs with respect to coverage of emergency department services¹⁶ and an exception for a QHP that does not include pediatric oral coverage if a stand-alone dental benefit plan covers these EHB and is offered through the same Exchange.¹⁷ QHPs also cannot be made to offer coverage for abortions as part of EHB.¹⁸

The Secretary must periodically review EHB and provide a report to Congress and the public containing:

- i. an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

⁹ *Id.* § 18022(b)(2)(A)(1).

¹⁰ *Id.* § 18022(b)(2)(A)(1).

¹¹ *Id.* § 18022(b)(4)(A).

¹² *Id.* § 18022(b)(4)(B).

¹³ *Id.* § 18022(b)(4)(C).

¹⁴ *Id.* § 18022(b)(4)(D).

¹⁵ *Id.* § 18022(e).

¹⁶ *See id.* § 18022(b)(4)(E). A QHP will not be treated as providing coverage for EHB unless it covers emergency department services without requiring prior authorization. *See id.* § 18022(b)(4)(E)(1). Further, a QHP will not be considered to cover EHB if it imposes a limitation on coverage on a provider of emergency department services that lacks a contractual relationship with the QHP that is more restrictive than what applies to providers with a contractual relationship to the QHP. *See id.* § 18022(b)(4)(E)(1). The QHP also must require the same cost-sharing for emergency department services provided in and out-of-network. *See id.* § 18022(b)(4)(E)(2).

¹⁷ *See id.* § 18022(b)(4)(F).

¹⁸ *See id.* § 18023(b)(1)(A)(i).

- ii. an assessment of whether the essential health benefits need to be modified or updated to account for changes in medical evidence or scientific advancement;
- iii. information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base; [and]
- iv. an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described [in the statute].¹⁹

Based on this periodic review, the Secretary then must periodically update EHB “to address any gaps in access to coverage or changes in the evidence base”²⁰

Both in initially defining and subsequently revising EHB, the Chief Actuary of the Centers for Medicare & Medicaid Services (“CMS”) must certify to Congress that the scope of EHB is equal to the scope of benefits provided under a typical employer plan,²¹ and the Secretary must provide notice and an opportunity for public comment.²²

Importantly, the statute does not prohibit issuers from providing benefits beyond what the Secretary defines as EHB.²³ A state also may require issuers to offer more coverage than EHB. The ACA, however, requires states to make payments to or on behalf of individuals enrolled in QHPs to defray the cost of benefits that state law requires QHPs to cover in addition to EHB.²⁴ As discussed in Section IV.A. below, HHS is considering softening this financial burden on states that select a benchmark subject to state mandates for 2014 and 2015, while it studies the issue, and excluding some state mandates from EHB beginning in 2016.²⁵ For plan years

¹⁹ *Id.* § 18022(b)(4)(G).

²⁰ *Id.* § 18022(b)(4)(H).

²¹ *See id.* § 18022(b)(2)(B).

²² *See id.* § 18022(b)(3)(D).

²³ *See id.* § 18022(b)(5).

²⁴ *See id.* § 18031(d)(3)(B); *see also id.* § 18054(c) (same regarding multi-state QHPs). Prior to amendment, Section 1311(d)(3)(B)(ii) of the ACA required states to “make payments to or on behalf of an individual eligible for the premium tax credit . . . to defray the cost to the individual of any additional benefits [that the state requires a QHP to offer beyond EHB] which are not eligible for such credit” But Section 10104(e)(1) of the ACA then amended Section 1311(d)(3)(B) by replacing the above language in subparagraph (ii) with the following language that is not restricted to individuals eligible for the premium tax credits:

(ii) STATE MUST ASSUME COST.—A State shall make payments—

(I) to an individual enrolled in a qualified health plan offered in such State; or

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits [that a State requires a QHP to offer beyond EHB].

²⁵ *See infra* notes 58-63 & accompanying text.

beginning on or after January 1, 2017, states also may seek an innovation waiver of EHB requirements under Section 1332 of the ACA.²⁶

III. Essential Health Benefits Fact Finding to Identify “Typical” Employer Plan

Following passage of the ACA, several entities engaged in fact finding to identify the scope of benefits provided under a typical employer plan. As required by the statute, the Department of Labor provided a report to HHS on April 15, 2011 summarizing the scope of benefits covered by employer-sponsored health insurance plans based on data from the 2008 and 2009 National Compensation Survey and DOL’s supplemental review of plan documents.²⁷ The Mercer consulting firm also conducted a survey of 779 employers in March 2011 concerning coverage of 26 health care services in 2010 and 2011.²⁸

HHS then “commissioned the [Institute of Medicine (“IOM”)] to recommend a process that would help HHS define the benefits that should be included in the EHB and update the benefits to take into account advances in science, gaps in access, and the effect of any benefit changes on cost.”²⁹ The resulting, comprehensive IOM report issued in October 2011 suggested explicit criteria and methods for HHS to use to define and update the essential health benefits package using, among other criteria, evidence of what works and consumer feedback.³⁰ A refrain throughout the report was the need to balance the desire to have comprehensive coverage with the need to keep premiums affordable. The IOM thus recommended that the Secretary first establish a premium cost target and then determine the scope of EHB based on what could be covered within this target.³¹ After surveying evidence of coverage offered by existing plans, the IOM recommended that EHB, at least initially, should reflect typical plans in the small employer market.³² The IOM report also emphasized the role of medical necessity decisions rooted in evidence and transparent appeals processes.³³ Although the IOM suggested that the Secretary define a specific national EHB standard,³⁴ the report also suggested that the

²⁶ See 42 U.S.C. § 18052.

²⁷ See Selected Medical Benefits: A Report from the Dep’t of Labor to the Dep’t of Health & Human Servcs. (Apr. 15, 2011), <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf>.

²⁸ See Health Care Reform: The Question of Essential Benefits, at 1 (Mercer 2011), available at <http://ribgh.org/resources/Mercer%20Survey%20Report%20201105.pdf>.

²⁹ Bulletin, *supra* note 2, at 2-3.

³⁰ See Cheryl Ulmer *et al.*, Essential Health Benefits: Balancing Coverage and Cost, 6-10 (IOM October 2011) [hereinafter IOM], <http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>.

³¹ *Id.* at 6-7.

³² *Id.*

³³ *Id.* at 6.

³⁴ *Id.* at 7.

Secretary use her discretion to permit states that operate their own Exchanges the flexibility to substitute an EHB plan that is actuarially equivalent to the National EHB plan.³⁵

HHS supplemented these fact finding efforts with its own analysis of available data on coverage and by holding public listening sessions in various locales around the country.³⁶

IV. Essential Health Benefits Federal Regulatory Guidance

Many expected HHS to issue regulations that would define with specificity the ingredients of EHB. Instead, on December 16, 2011, the Center for Consumer Information & Insurance Oversight in HHS issued a Bulletin outlining and seeking comment on its intended regulatory approach to defining essential health benefits.³⁷ Following review of approximately 11,000 informal comments,³⁸ HHS then released a Frequently Asked Questions on Essential Health Benefits Bulletin (“FAQ”) on February 17, 2012 to provide additional guidance on its approach, which it intends to formalize in future rulemaking.³⁹

Like the IOM report, the Bulletin repeatedly cited the need “to balance comprehensiveness, affordability, and State flexibility and to reflect public input received to date.”⁴⁰ Based on its review of data concerning employer coverage, HHS found that “products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover” but instead “differ mainly in cost-sharing provisions, . . . [which are] not taken into account in determining EHB.”⁴¹ HHS also found that these plans and products generally cover all ten of the statutory EHB categories.⁴²

³⁵ *Id.* at 9.

³⁶ See Bulletin, *supra* note 2, at 3-8; Dep’t of Health & Human Servcs., Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans; Proposed Rule, 77 Fed. Reg. 33,133, 33,134 (June 5, 2012) [hereinafter EHB Data Collection PR, 77 Fed. Reg. at X].

³⁷ See Bulletin, *supra* note 2. HHS specifically noted that its EHB Bulletin related only to covered services and not to plan cost sharing, the calculation of actuarial value, or EHB implementation in the Medicaid program, which would be the subject of future regulatory guidance. *Id.* at 1.

³⁸ See EHB Data Collection PR, *supra* note 36, 77 Fed. Reg. at 33,134. Although HHS invited and received informal public comments in response to the Bulletin until January 31, 2012, it has not to date made these comments accessible on the agency’s web site. Several of these informal comments have been collected and made available to the public on the State Refor(u)m web site, <http://www.statereforum.org/discussions/essential-health-benefits>.

³⁹ See FAQ, *supra* note 5.

⁴⁰ Bulletin, *supra* note 2, at 1.

⁴¹ *Id.* at 4. For purposes of EHB, HHS initially defined “products” as “services covered as a package by an issuer, which may have several cost-sharing options and riders as options,” which it distinguished from a “plan,” which “refers to the specific benefits and cost-sharing provisions available to an enrolled consumer.” *Id.* at 9 n.26. In more recent guidance, HHS has refined these definitions: “[product is] a package of benefits an issuer offers that is reported to State regulators in an insurance filing. Generally, this filing describes a set of benefits and often a

HHS noted, however, that coverage of some services varied among markets and plans and products within markets.⁴³ For example, while the FEHBP standard option covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications, coverage of these benefits under small employer and state employee plans varies.⁴⁴ Conversely, some benefits are covered by small group plans but not by the FEHBP or state employee plans. Some states, for example, mandate coverage of in-vitro fertilization or applied behavior analysis (ABA) for children with autism, which mandates do not apply to the FEHBP.⁴⁵

HHS then focused on three specific subsets of benefits for which coverage varies among plans, products, and markets: mental health and substance abuse disorder services; pediatric oral and vision services; and habilitative services.⁴⁶ Although plans generally cover inpatient and outpatient mental health and substance use disorder services, small group plans tend to limit the extent of this coverage. In addition, although the ACA includes behavioral health treatment (BHT) as a component of the mental health and substance abuse disorder category, HHS found that it is unclear from summary plan documents whether BHT typically is covered. One notable exception is for behavioral treatment for autism, which tends to be a covered service only when states mandate its coverage.⁴⁷ Dental and vision care services are sometimes covered under comprehensive health plans and other times by stand-alone plans.⁴⁸ Perhaps the least is known about coverage of habilitative services, which health plans generally do not identify as a separate category of services. Although there is no accepted definition of these services, suggested definitions “focus on . . . learning new skills or functions – as distinguished from rehabilitation[,] which focuses on relearning existing skills or functions”⁴⁹ Some plans provide coverage for physical therapy (PT), occupational therapy (OT), and speech therapy (ST)

provider network, but does not describe the manner in which benefits may be tailored, such as through the addition of riders. For purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product excluding all riders.” FAQ, *supra* note 5, at 3. Cf. Dep’t of Health & Human Servcs., Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans; Final Rule, 77 Fed. Reg. 42,658, 42,659 (July 20, 2012) (to be codified at 45 C.F.R. pt. 156) [hereinafter “EHB Data Collection FR, 77 Fed. Reg. at X”] (defining, for purposes of EHB data collection, health plan as “the discrete pairing of a package of benefits and a particular cost sharing option (not including premium rates or premium quotes) . . . [, which] is collected as a unique combination of benefits available for an additional premium (often referred to as ‘riders’) as well as benefits that are legally considered riders but are not optional for consumers (‘mandatory riders’), if those benefits are part of the most commonly purchased set of benefits within the product by enrollment,” and health insurance product as “a package of benefits that an issuer offers that is reported to state regulators in an insurance filing”).

⁴² Bulletin, *supra* note 2, at 4.

⁴³ *Id.* at 5.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.* at 5-6.

⁴⁷ *Id.*

⁴⁸ *Id.* at 6.

⁴⁹ *Id.* See also 42 U.S.C. § 1396n(c)(5)(A) (defining habilitation in Medicaid context).

for habilitative services under the coverage for rehabilitative benefits, although this coverage often includes visit limits, and some plans will not cover these services for patients with an autism diagnosis.⁵⁰

The Bulletin also considered the scope of state benefit mandates. Although states vary widely in what they require to be covered, HHS analysis shows that virtually all services mandated are also covered in states that do not impose the same mandates and in federal plans that are not subject to state mandates. In-vitro fertilization and ABA therapy for autism, however, are exceptions to this general rule.⁵¹

After considering the current landscape of employer coverage, HHS chose not to prescribe a single, national definition of EHB. Instead, HHS signaled in the Bulletin and FAQ its intent, at least in plan years 2014 and 2015, to permit states flexibility to select a benchmark or reference plan from a menu of existing health care plans identified by HHS. As discussed in more detail below, states will need to supplement benchmarks that fail to provide coverage in the 10 ACA categories. Issuers then would be permitted to adopt the state benchmark or to craft a substantially equal package of benefits by making actuarially equivalent substitutions.⁵²

A. Selecting and Supplementing a State Benchmark

The first step in this process is for states to select a benchmark from ten candidates in four potential benchmark plan types that HHS believes reflect “both the scope of services and any limits offered by a ‘typical employer plan’ in that State . . .”⁵³:

1. the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
2. any of the largest three State employee health benefit plans by enrollment;
3. any of the largest three national FEHBP plan options by enrollment; or
4. the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in a State.⁵⁴

HHS has clarified that a plan encompasses “the benefits covered by the product excluding all riders.”⁵⁵ The Agency’s intent is to have each state select only one EHB benchmark plan that would apply in its individual and small group markets both inside and outside of the

⁵⁰ Bulletin, *supra* note 2, at 6.

⁵¹ *Id.* at 7.

⁵² *See id.*; FAQ, *supra* note 5.

⁵³ Bulletin, *supra* note 2, at 8.

⁵⁴ *Id.* at 9 (internal footnote paraphrased). In identifying which plans are potential benchmarks in each state, HHS intends to use enrollment data from the first quarter of the year two years’ prior to the year of coverage. *Id.* Thus, for plan year 2014, HHS is using enrollment data for the first quarter of 2012.

⁵⁵ FAQ, *supra* note 5, at 3. *See generally supra* note 41 (explaining definitional difference between plans and products).

Exchange.⁵⁶ Regardless of the benchmark selected, HHS has indicated that EHB will include the preventive health services set forth in Section 2713 of the PHSA.⁵⁷

Given the ACA's requirement that states defray the cost of state mandates that exceed EHB in QHPs,⁵⁸ a critical issue for states to consider when selecting a benchmark is the extent to which the state's benefit mandates exceed EHB and the extent to which these state mandates apply to the various potential benchmarks. HHS intends to propose a transition period for states: in 2014 and 2015, if a state selects a benchmark plan that is subject to its state benefit mandates, then the EHB benchmark will be deemed to include any state-mandated benefits enacted by December 31, 2011;⁵⁹ but if a state selects a benchmark that is not subject to all of the state mandates, the state will be responsible for the costs of covering these state-mandated benefits that exceed the benefits covered by the EHB benchmark.⁶⁰ Thus, because the FEHBP is not bound to comply with state mandates, a state that selects a federal benchmark that does not include all of the state's mandates would be required to pay for these benefits in excess of EHB, as established by the benchmark.⁶¹ Although a state's mandates generally apply to small group and individual plans sold in its state, some state mandates apply only in one market or to certain kinds of insurers. As the FAQ illustrates, if a state selects a small group plan as its benchmark, it will have to defray the costs of offering benefits mandated in the individual market or for HMOs, for example, which are not otherwise part of the state EHB benchmark.⁶² During this two-year transition period, HHS will study this issue and may exclude some state mandates from EHB for 2016 and beyond.⁶³

Although the potential benchmark plans from which states may choose may be typical of what employers are offering on the market, they may not cover the ten categories required by the ACA.⁶⁴ A state that selects a benchmark plan that does not provide coverage in each of

⁵⁶ See FAQ, *supra* note 5, at 1. The applicable EHB benchmark for a non-grandfathered small group plan that is available to employees who reside in more than one state is the one for the state where the policy was issued. See FAQ, *supra* note 5, at 5.

⁵⁷ FAQ, *supra* note 5, at 5.

⁵⁸ See 42 U.S.C. § 18031(d)(3)(B)(ii).

⁵⁹ See FAQ, *supra* note 5, at 2. Under HHS's planned regulatory approach, if a state enacted a mandate after December 31, 2011, it could only be included in EHB for plan years 2014 and 2015 if it is part of the benchmark independent of the mandate. See *id.*

⁶⁰ Bulletin, *supra* note 2, at 9-10; see also FAQ, *supra* note 5, at 1.

⁶¹ Bulletin, *supra* note 2, at 10.

⁶² See FAQ, *supra* note 5, at 1-2.

⁶³ Bulletin, *supra* note 2, at 10; see also FAQ, *supra* note 5, at 2. As discussed *infra* notes 87-88 and accompanying text, because Section 2711 of the PHSA prohibits annual or lifetime dollar limits on EHB, any benefit within the benchmark with a dollar limit, including those that are mandated by state law, "would be incorporated into the EHB definition without the dollar limit." FAQ, *supra* note 5, at 4.

⁶⁴ Bulletin, *supra* note 2, at 10.

the ten categories will have to supplement the benchmark.⁶⁵ This benchmark supplementation requirement would apply if coverage in a category is only available by purchasing a rider.⁶⁶

As a general matter, HHS intends to require a state to supplement missing categories by using benefits provided in any of the other potential benchmark plans for that state that include coverage in the missing category.⁶⁷ If a state does not elect to choose its own benchmark, HHS expects to make the largest plan by enrollment in the largest product in a state's small group market the default benchmark.⁶⁸ HHS intends to be more prescriptive about how states supplement the default benchmark. When the default benchmark plan fails to provide coverage in one or more ACA category, the first source for supplementation would be the second largest small group potential benchmark, followed by the third largest small group benchmark option. If none of the small group potential benchmarks provides coverage in the missing category, the benchmark should be supplemented using the FEHBP plan with the highest enrollment.⁶⁹

It appears from recent regulatory guidance that HHS also is considering offering states a third choice when it comes to selecting and supplementing a benchmark.⁷⁰ Under this alternate approach, a state that selects any of the three largest small group benchmark options as its benchmark then could, if it wishes, leave it to HHS to "ensure coverage in all ten statutorily required categories."⁷¹ HHS has not explained how it would supplement this benchmark, if any of the 10 categories required supplementation.

Because habilitative services, pediatric oral services, and pediatric vision services are the most common EHB categories that are not included in benchmark candidates,⁷² HHS is considering alternative options for supplementing benchmarks that lack these categories. As HHS wrestles with how to define habilitative services,⁷³ for example, it is considering two options for supplementing a benchmark that lacks this category. The first option would be to offer habilitative services "at parity with rehabilitative services," such that a plan that covers services like PT, OT, and ST for rehabilitation also must cover them "in similar scope, amount,

⁶⁵ See *id.*; see also FAQ, *supra* note 5, at 2.

⁶⁶ FAQ, *supra* note 5, at 3.

⁶⁷ See Bulletin, *supra* note 2, at 10; see also FAQ, *supra* note 5, at 2.

⁶⁸ Bulletin, *supra* note 2, at 9; FAQ, *supra* note 5, at 6.

⁶⁹ See FAQ, *supra* note 5, at 2.

⁷⁰ Supporting Statement for Paperwork Reduction Act Submission: Health Care Reform Insurance Web Portal and Supporting Authority Contained in Sections 1103 and 10102 of the Patient Protection and Affordability Care Act, P.L. 111-148 (PPACA) & Apps. G & H, CMS-10320 (June 1, 2012), available at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1247405.html>.

⁷¹ *Id.*, Appdx. G, at 5.

⁷² Bulletin, *supra* note 2, at 10; see also FAQ, *supra* note 5, at 2.

⁷³ HHS noted differences in definitions of habilitative services used in Medicaid, Medicare, and commercial insurance and recommended by the NAIC and requested "comment on the advantages and disadvantages of including maintenance of function as part of the definition" Bulletin, *supra* note 2, at 11.

and duration for habilitation.”⁷⁴ HHS also is considering a transitional alternative pursuant to which plans would decide which habilitative services to cover, and HHS then would define habilitative services after evaluating these choices.⁷⁵

Similarly, HHS is considering permitting a state to select benefits from one of two sources to supplement a benchmark lacking coverage for pediatric oral services, the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment or the State’s Children’s Health Insurance Program (SCHIP) program.⁷⁶ Because SCHIP does not require coverage of pediatric vision services, HHS plans to propose that a state supplement this missing category using the “benefits covered by the FEDVIP vision plan with the largest enrollment.”⁷⁷ HHS also requested comment on using a transitional approach for pediatric dental and vision services, akin to its proposed alternative for habilitative supplementation.⁷⁸

B. Issuer Substitution of the Benchmark

Once a state (or HHS) establishes an EHB benchmark, supplemented if necessary to include all ten ACA categories, HHS intends to give issuers some flexibility to tinker with the specific coverage and design options as long as the benefits covered “are ‘substantially equal’ to the benefits of the benchmark plan”⁷⁹ Under the contemplated benchmark approach, which is modeled after a benchmark approach Congress has adopted for SCHIP and certain Medicaid populations,⁸⁰ issuers either could adopt the state EHB benchmark or adjust “both the specific services covered and any quantitative limits,” as long as the resulting plan covers all ten categories and any substitution is actuarially equivalent and does not otherwise violate the law.⁸¹ In addition, the resulting “plan must be substantially equal to the benchmark plan[] in

⁷⁴ *Id.*; see also FAQ, *supra* note 5, at 2 (“A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.”).

⁷⁵ Bulletin, *supra* note 2, at 11.

⁷⁶ *Id.*; see also FAQ, *supra* note 5, at 2-3. For states that do not have a SCHIP program, they “may establish a benchmark that is consistent with the applicable SCHIP standards.” Bulletin, *supra* note 2, at 11 n.31 (citing <http://www.cms.gov/SMDL/downloads/CHIPRA%20Dental%20SHO%20Final%20100709revised.pdf>). HHS further intends to propose that the definition of EHB does not include non-medically necessary orthodontic coverage. See Bulletin, *supra* note 2, at 11.

⁷⁷ Bulletin, *supra* note 2, at 11; see also FAQ, *supra* note 5, at 3.

⁷⁸ Bulletin, *supra* note 2, at 11.

⁷⁹ *Id.* at 12. HHS does not intend, however, to permit states to adjust the benefits offered by benchmarks other than to supplement them, as required to ensure coverage of the ten ACA categories, unlike benchmark equivalent benefits or Secretary-approved benefits under Medicaid and SCHIP. See FAQ, *supra* note 39, at 5.

⁸⁰ Bulletin, *supra* note 2, at 8 & n.24-25 (citing Balanced Budget Act of 1997, Public Law 105-33 and 42 C.F.R. §§ 457.410 & 457.420).

⁸¹ *Id.* at 12; see also FAQ, *supra* note 5, at 3. HHS has noted that the EHB requirements that substitutions be “actuarially equivalent” and benefits be “substantially equal” to the benefits of the benchmark plan employ the same standards and measures that have been defined in SCHIP. See Bulletin, *supra* note 2, at 12 & n. 32 & 33 (citing 42 C.F.R. §§ 457.420 and 457.431); FAQ, *supra* note 5, at 3 (citing 42 C.F.R. § 457.431).

both the scope of benefits offered and any limitations on those benefits[,] such as visit limits.”⁸² Such limits, however, may not discriminate in benefit design.⁸³

Initially, HHS indicated that it was considering whether to permit substitutions only within each of the ten ACA categories or whether also to authorize substitutions across categories.⁸⁴ Recognizing that the latter flexibility introduces “the potential for eliminating important services or benefits in particular categories,” the agency sought comment on whether to apply a higher level of scrutiny to cross category substitutions.⁸⁵ Although HHS has not expressly stated that it no longer is considering authorizing substitutions across categories, it is notable that in its more recent FAQ, HHS only refers to its intent to grant issuers flexibility to make actuarially equivalent substitutions within the ten ACA categories.⁸⁶

HHS also proposes a different species of substitution with respect to non-dollar limits on benefits. Because Section 2711 of the PHSA prohibits annual or lifetime dollar limits on EHB, any benefit within the benchmark with a dollar limit, including those that are mandated by state law, “would be incorporated into the EHB definition without the dollar limit.”⁸⁷ Yet, HHS intends to permit plans “to impose non-dollar limits . . . that are at least actuarially equivalent to [] annual dollar limits” on benefits in the benchmark.⁸⁸ Under this version of substitution, plans would be permitted to make substitutions that are actuarially equivalent to a benefit limitation that expressly was stripped from the benchmark rather than substitutions that are actuarially equivalent to benefits contained in the benchmark.

HHS also intends to propose flexibility with respect to pharmacy benefits. Similar to the flexibility built into Medicare Part D, the agency contemplates permitting a plan to select the specific drugs it will offer in its formulary as long as it covers at least one drug in each category or class of drugs included in the benchmark.⁸⁹

C. Federal Data Collection and Reporting Benchmark Selection

HHS anticipates that states will select a benchmark in the third quarter of the year two years prior to the year of coverage.⁹⁰ To limit market disruption, the initial selection, which is to be made some time before September 30, 2012, will be in effect for coverage years 2014 and

⁸² FAQ, *supra* note 5, at 3.

⁸³ *Id.*

⁸⁴ Bulletin, *supra* note 2, at 12.

⁸⁵ *Id.*

⁸⁶ FAQ, *supra* note 5, at 1, 3, 4.

⁸⁷ *Id.* at 4.

⁸⁸ *Id.* See *supra* note 5 for a discussion of the application of Section 2711 to grandfathered, large group, and self-insured plans.

⁸⁹ Bulletin, *supra* note 2, at 12-13.

⁹⁰ *Id.* at 9; FAQ, *supra* note 5, at 5.

2015.⁹¹ To help states identify the potential benchmarks from which each may choose by September 30, 2012, HHS released a list of the three largest nationally available FEHBP plans, the largest FEDVIP dental plan, the largest FEDVIP vision plan, and the three largest small group market products in each state, based on March 31, 2012 enrollment data.⁹² Although the federal government collects data on small group product enrollment, it has not been collecting “enrollment information on each specific combination of benefits and cost sharing that make up a plan.”⁹³ States, though, can use plan enrollment data to identify the largest plan by enrollment in each of the largest small group products identified by HHS to evaluate its small group benchmark options. Each state also is responsible for identifying the largest three state employee health benefit plans by enrollment and the largest insured commercial non-Medicaid HMO operating in each state.⁹⁴

To help states select among their potential benchmark options⁹⁵ and to help issuers know what benefits will be included in the benchmark,⁹⁶ HHS also adopted a final rule on July 20, 2012 which is effective August 20, 2012 and requires issuers of the three largest small group products in each state to submit data regarding benefits and coverage. Under 45 C.F.R. § 156.120, each of these issuers is required to submit benefit and enrollment data to HHS for its health plan within these products with the highest enrollment, as determined by the issuer, including information about all health benefits in the plan; quantitative treatment limitations on coverage, such as “limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment;”⁹⁷ drug coverage, including a list of covered drugs; and plan enrollment data.⁹⁸

⁹¹ See FAQ, *supra* note 5, at 1 (clarifying that “the specific set of benchmark benefits selected in 2012 would apply for plan years 2014 and 2015 . . . [to] limit market disruption”).

⁹² See Center for Consumer Inf. & Ins. Oversight, Centers for Medicare & Medicaid Servcs., Essential Health Benefits: List of the Largest Three Small Group Products by State, at 5-15 (July 3, 2012); see also FAQ, *supra* note 5, at 5-15. The small group products include those open for enrollment and closed but still active but not association products or those that are not major medical plans. *Id.* at 4.

⁹³ FAQ, *supra* note 5, at 4.

⁹⁴ See *id.* at 5.

⁹⁵ See 45 C.F.R. § 156.120; EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,658. The EHB Data Collection Final Rule also adopts a process for recognizing accrediting agencies to certify qualified health plans, as required by Section 1311(c)(1)(D)(i) of the ACA. See 45 C.F.R. §156.275; EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,658, 42,662-68.

⁹⁶ 45 C.F.R. § 156.120(a); see also EHB Data Collection PR, *supra* note 38, at 33,135.

⁹⁷ EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,659. In adopting this final rule, HHS omitted nonquantitative limits on benefits, such as prior authorization and step therapy requirements, from the definition it adopted for treatment limitations, even though these limits had been part of its proposed definition, finding that such data “are not necessary for benchmark plan purposes” *Id.* at 42,659-60. HHS also refused commentators’ request to collect additional information, “such as data on exclusions, medical necessity, rehabilitative services, cost-sharing (including premiums and co-pays), additional drug data, additional data on treatment limits, and a more extensive list of benefits.” *Id.* at 42,660.

⁹⁸ See 45 C.F.R. § 156.120(b)(2) (& (d)).

Notably, HHS used a different definition of plan for purposes of data collection under this rule than it did when defining EHB. While riders are expressly excluded from the definition of plans for purposes of defining EHB,⁹⁹ riders are included in the definition of plan that it adopted for purposes of EHB data collection.¹⁰⁰ Thus, issuers required by the EHB data collection rule to provide data must do so for “the largest plan by enrollment within that product . . . [, which] will be comprised of the most commonly purchased set of benefits, which may include riders.”¹⁰¹

On June 1, 2012, HHS issued a Paperwork Reduction Act (“PRA”) package that was associated with the proposed data collection rule and detailed the specifics of the data elements it seeks to collect from potential EHB benchmark plans.¹⁰² In addition to collecting benefit data from the issuers of the potential default benchmarks, as outlined in the data collection rule, HHS also intends to require states selecting their own benchmarks to provide information about their benchmark selections.¹⁰³ HHS anticipates creating a standardized format to collect information from each state regarding its EHB package, which “would include the benefits offered in the benchmark plan, any supplemental benefits required to ensure coverage within all ten statutory categories of benefits, and any adjustments to include coverage for applicable state mandates enacted before December 31, 2011.”¹⁰⁴ The agency also plans to ask states to voluntarily provide information regarding state mandates and to ask issuers to voluntarily disclose if they plan to apply for certification to offer stand-alone dental plans through any of the Exchanges.¹⁰⁵ The comment period for the PRA package closed on August 5, 2012,¹⁰⁶ after which time HHS was to provide more details regarding the format and

⁹⁹ FAQ, *supra* note 5, at 3. See generally *supra* note 41 (explaining definitional difference between plans and products).

¹⁰⁰ EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,659-60.

¹⁰¹ *Id.* at 42,660. See generally Letter dated July 5, 2012 from Jesse Cross-Call et al., Center on Budget and Policy Priorities to Centers for Medicare & Medicaid Services, attachment at 3 (“If HHS decides to define a plan as the benefits covered by a product excluding riders, issuers of the highest enrolled products should still be required to submit data on the riders attached to those plans. That is because high enrollment in a plan can be attributed, at least in part, to the availability of rider policies. In order to allow state officials and the public to truly evaluate the elements that went into making a plan attractive to consumers, data on all the benefits that comprise that plan should be submitted to HHS as part of the data collection. Data on riders should be a part of this data collection, even though the services they cover will need to be supplemented from other benchmark options.”), [http://op.bna.com/hl.nsf/id/shad-](http://op.bna.com/hl.nsf/id/shad-8vxpdw/$File/EHB%20Data%20Collection%20Comment%20%28CBPP,%2007.05.12%29.pdf)

[8vxpdw/\\$File/EHB%20Data%20Collection%20Comment%20%28CBPP,%2007.05.12%29.pdf](http://op.bna.com/hl.nsf/id/shad-8vxpdw/$File/EHB%20Data%20Collection%20Comment%20%28CBPP,%2007.05.12%29.pdf).

¹⁰² Supporting Statement for Paperwork Reduction Act Submission: Health Care Reform Insurance Web Portal and Supporting Authority Contained in Sections 1103 and 10102 of the Patient Protection and Affordability Care Act, P.L. 111-148 (PPACA) & Apps. G & H, CMS-10320 (June 1, 2012) [hereinafter PRA], *available at* <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1247405.html>.

¹⁰³ *Id.* at 1.

¹⁰⁴ FAQ, *supra* note 5, at 6.

¹⁰⁵ PRA, *supra* note 102, at 1 & 6; Appendix G.

¹⁰⁶ See EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,660, 42,668.

degree of specificity of the required data submission,¹⁰⁷ which was due by September 4, 2012.¹⁰⁸

HHS expects to provide states with information regarding default benchmark plans in the Fall of 2012.¹⁰⁹ As discussed below in Section V.B., HHS defers to the states to determine which entity within each state has the authority and responsibility to select its benchmark.¹¹⁰ HHS then intends to publish state benchmarks for notice and comment¹¹¹ and to issue additional regulations regarding EHB in the near future.¹¹²

HHS plans to evaluate how this state-driven benchmark approach works for 2014 and 2015 before deciding how to define EHB for plan year 2016 and thereafter.¹¹³ The Bulletin solicited comment on how to fulfill the agency's statutory obligation to periodically review and update EHB on an ongoing basis.¹¹⁴

V. New Jersey's Next Steps

A. Designate a Benchmark Plan

New Jersey needs to decide whether to (1) select its own benchmark plan or (2) accept the default option of the largest plan by enrollment in the largest product in its Small Employer Health Benefits Program (SEHBP). HHS has indicated that states that wish to select their own benchmarks must do so by the third quarter of 2012, that is, by September of this year.¹¹⁵ The benchmark selected will remain in effect for plan years 2014 and 2015. HHS explains that "[t]his schedule would ensure plans have time to determine benefit offerings before QHP applications are due."¹¹⁶ The precise due date will vary by state, bearing in mind that the Exchange "must complete the certification of QHPs that will be offered during the open enrollment period prior to the beginning of such period[,]"¹¹⁷ which is October 1, 2013.¹¹⁸

HHS has reported that the largest product in New Jersey's SEHBP in the first quarter of 2012 (January-March) was Horizon HMO.¹¹⁹ The product with the second largest enrollment

¹⁰⁷ *Id.* at 42,661.

¹⁰⁸ See 45 C.F.R. § 156.120(e); EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,661.

¹⁰⁹ See FAQ, *supra* note 5, at 6.

¹¹⁰ See *id.* HHS will look to each state's Medicaid agency to implement "EHB through the Medicaid benchmark coverage option." *Id.*

¹¹¹ EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,661.

¹¹² See EHB Data Collection FR, *supra* note 41, 77 Fed. Reg. at 42,659.

¹¹³ Bulletin, *supra* note 2, at 9; see also FAQ, *supra* note 5, at 1.

¹¹⁴ Bulletin, *supra* note 2, at 13; see also FAQ, *supra* note 5, at 1.

¹¹⁵ See FAQ, *supra* note 5, at 4.

¹¹⁶ *Id.* at 5.

¹¹⁷ 45 C.F.R. § 155.1010(a)(1).

¹¹⁸ *Id.* § 155.410(b).

¹¹⁹ See Center for Consumer Inf. & Ins. Oversight, Centers for Medicare & Medicaid Servcs., Essential Health Benefits: List of the Largest Three Small Group Products by State, at 11-12 (July 3, 2012).

during the first quarter of this year was Horizon Blue Cross Blue Shield of NJ (POS), and the product with the third largest enrollment was Aetna Health Inc. (Aetna Health Maintenance Organization).¹²⁰ HHS has also provided the states with information on the top three federal employee plans, which are also benchmark options. To round out the list of benchmark options, New Jersey will need to identify its three largest state employee plans and its largest commercial HMO.

As outlined above, New Jersey's benchmark likely will need to be supplemented to ensure that it provides coverage in all ten categories of EHB. If New Jersey selects its own benchmark, it will be free to supplement it from any other benchmark option that offers the missing benefit. HHS is considering permitting states that select one of the three largest products in their small group markets as their benchmark to cede responsibility for supplementation to HHS. Should HHS do this—that is, should it offer to take responsibility for supplementation for states that choose small group market plans—and should New Jersey choose one of its small group market plan options, the State will have to decide whether or not to leave it up to HHS to supplement it. If New Jersey foregoes its option to designate a benchmark and instead accepts the default benchmark that HHS intends to propose, the default benchmark plan will be supplemented as necessary from the second largest – and then, if necessary, from the third largest – small group potential benchmark, and then, if no small group potential benchmark satisfies the category, from the FEHBP with the highest enrollment. To the extent HHS offers states alternative ways to supplement particular ACA benefit categories, such as habilitative services, pediatric oral services, and pediatric vision services, New Jersey will need to consider its options.

Once New Jersey's benchmark plan has been selected, the State will submit to HHS an "EHB package," which, as discussed above, will include "the benefits offered in the benchmark plan, any supplemental benefits required to ensure coverage within all ten statutory categories of benefits, and any adjustments to include coverage for applicable State mandates enacted before December 31, 2011."¹²¹ HHS has explained that while it "is currently evaluating options for collecting a State's benchmark plan selection and benefit information[,] it "anticipates that submissions will be collected from States in a standardized format that includes the name of the benchmark plan along with benefit information and, if necessary, the benefits used to ensure coverage within a missing statutory category."¹²² HHS will then determine if New Jersey's EHB package meets the Affordable Care Act's requirements.¹²³

¹²⁰ *Id.*

¹²¹ FAQ, *supra* note 5, at 6.

¹²² *Id.*

¹²³ Colorado's Essential Health Benefits Benchmark Plan: Response to Stakeholder Questions, at 3 (July 26, 2012), available at <http://www.dora.state.co.us/insurance/consumer/fhcr/EHBfrequentlyaskedquestions072712.pdf> (explaining that "[a]fter Colorado chooses a benchmark, HHS will determine if the benchmark meets ACA requirements. Then, Colorado carriers will be given details about the benchmark and asked to price that plan.").

B. Designation: By Whom

HHS has specified that states are free “to select a benchmark plan from the options provided by HHS by whatever process and through whatever State entity is appropriate under State law.”¹²⁴ HHS “expects that the State executive branch would have the authority to select the benchmark plan[,]” but notes that “[i]t is also possible that, in some States, legislation would be necessary for benchmark plan selection.”¹²⁵ States that have selected or made progress toward selecting their benchmark plans have taken a number of different approaches. In Arkansas and Utah, for example, the State department of insurance will select the plan.¹²⁶ In Oregon, the plan is to be selected by the Exchange Board and by the Oregon Health Policy Board.¹²⁷ In California and Washington, the two States which have completed the selection process, the legislatures passed legislation setting forth each State’s benchmark plan choice.¹²⁸

In New Jersey, the Department of Banking and Insurance (“DOBI”) “is invested with broad general powers of administration over all the laws of the State relative to insurance.”¹²⁹ The Commissioner of DOBI has the authority to “[f]ormulate, adopt, issue and promulgate, pursuant to the ‘Administrative Procedure Act,’ . . . in the name of the department, rules and regulations authorized by law for the efficient conduct of the work and general administration of the department, and the appropriate regulation of the institutions, companies, agencies, boards, commissions, and other entities within its jurisdiction, including licensees, officers and employees as authorized by law[.]”¹³⁰

The selection of a benchmark plan would seem to be within this broad grant of authority without further legislative action. Were the Commissioner’s selection to be challenged as beyond his delegated authority, a reviewing court likely would find such action to be “within the fair contemplation of the delegation” in DOBI’s enabling statute to regulate insurance in the State, particularly given that “the grant of authority to an administrative agency is to be

¹²⁴ FAQ, *supra* note 5, at 6.

¹²⁵ *Id.*

¹²⁶ Defining Essential Health Benefits For Arkansas’ Federally Facilitated Health Benefits Exchange, at 17 (May 29, 2012) (explaining that “the issue now goes before the Arkansas Insurance Commissioner for final consideration.”). Office of Legislative Research and General Counsel, Essential Health Benefits, at 12 (June 7, 2012) (explaining that it is the role of the Health System Reform Task Force to “recommend to the [insurance] commissioner, no later than September 1, 2012, a benchmark plan for the state’s essential health benefits”).

¹²⁷ Oregon Health Policy and Research, <http://cms.oregon.gov/oha/OHPR/pages/ehb/index.aspx> (last visited Aug. 2, 2012)(explaining that the state’s workgroup would present its recommendation to the Oregon Health Insurance Exchange Board and the Oregon Health Policy Board).

¹²⁸ An Act to Add Section 1367.005 to the Health and Safety Code, and to Add Section 10112.27 to the Insurance Code, Relating to Health Care Coverage, S.B. 951 (2012)(to be codified at Ca. Health & Safety Code § 1367.005 and Ca. Ins. Code § 10112.27); Affordable Care Act Implementation, H.B. 2319 (2012)(to be codified at Wa. Ch. 48.43 § 13.

¹²⁹ *In re Reorganization of the Medical Inter-Insurance Exchange of New Jersey*, 328 N.J. Super. 344, 356 (App.Div. 2000). See also N.J. Stat. § 17:1-1 (charging DOBI with “the execution of all laws relative to insurance”).

¹³⁰ N.J. Stat. § 17:1-15(e).

liberally construed in order to enable the agency to accomplish its statutory responsibilities.”¹³¹ That said, the Legislature could certainly decide to act directly to select a benchmark plan, as have legislatures in other states. Should it decline to do so, the most salient legal question remaining would be whether the Commissioner would be required by New Jersey law to act pursuant to notice and comment rulemaking to select a benchmark plan.

Agencies generally enjoy flexibility to choose whether to implement legislative policy through formal rulemaking, adjudicatory hearings, or informal agency action, as long as their procedures comply with the requirements of New Jersey’s Administrative Procedure Act (“APA”), N.J.S.A. § 52:14B-1 to -15, and due process.¹³² The APA defines an administrative adjudication as “any and every final determination, decision or order made or rendered in any contested case.”¹³³ A contested case, in turn, is defined as determining the “legal rights, duties, obligations, privileges, benefits, or other legal relations of specific parties . . . after opportunity for an agency hearing.”¹³⁴ The APA then defines an “administrative rule” or “rule” as an agency’s “statement of general applicability and continuing effect that implements or interprets law or policy, or describes the organization, procedure or practice requirements of any agency.”¹³⁵ While a rule “includes the amendment or repeal of any rule,” it “does not include: (1) statements concerning the internal management or discipline of any agency; (2) intraagency and interagency statements; and (3) agency decisions and findings in contested cases.”¹³⁶ An agency must comply with notice and comment requirements set forth in the APA before enacting administrative rules, including requirements that it provide at least 30 days’ notice of its intended action and permit interested parties to submit comments and data on the proposed action, which the agency must consider before proceeding with the adoption of the rule.¹³⁷

In addition to these formal adjudication and rulemaking procedures, agencies also may act informally.¹³⁸ Although informal agency action comprises “the bulk of the activity of most administrative agencies,”¹³⁹ the APA does not define this term. The New Jersey Supreme Court has described informal agency action as “any determination that is taken without a trial-type hearing, including investigating, publicizing, negotiating, settling, advising, planning, and

¹³¹ N.J. State League of Municipalities v. Dep’t of Cmty. Affairs, 158 N.J. 211, 223-24 (1999).

¹³² See *In re Provision of Basic Generation Service for Period Beginning June 1, 2008*, 205 N.J. 339, 347 (2011).

¹³³ See N.J. Stat. § 52:14B-2(c).

¹³⁴ *Id.* § 52:14B-2(b).

¹³⁵ *Id.* § 52:14B-2(e).

¹³⁶ *Id.*

¹³⁷ *Id.* § 52:14B-4.

¹³⁸ *Northwest Covenant Med. Ctr. v. Fishman*, 167 N.J. 123, 136 (2001).

¹³⁹ *Id.* at 137 (2001) (internal citation omitted).

supervising a regulated industry.”¹⁴⁰ In other words, informal action “is statutorily authorized agency action that is neither adjudication nor rulemaking.”¹⁴¹

The Court has recognized that “the line between agency rulemaking and adjudication, on the one hand, and informal action, on the other, can become blurred.”¹⁴² In wrestling with this line drawing problem, the Court in *Metromedia v. Director, Division of Taxation* identified six features of administrative rules, namely, that the agency determination:

- (1) is intended to have wide coverage encompassing a large segment of the regulated or general public, rather than an individual or a narrow select group;
- (2) is intended to be applied generally and uniformly to all similarly situated persons;
- (3) is designed to operate only in future cases, that is, prospectively;
- (4) prescribes a legal standard or directive that is not otherwise expressly provided by or clearly and obviously inferable from the enabling statutory authorization;
- (5) reflects an administrative policy that (i) was not previously expressed in any official and explicit agency determination, adjudication or rule, or (ii) constitutes a material and significant change from a clear, past agency position on the identical subject matter; and
- (6) reflects a decision on administrative regulatory policy in the nature of the interpretation of law or general policy.¹⁴³

If application of these factors suggests that an agency action is fairly considered a “rule” and not an informal action, the agency must proceed by formal notice and comment rulemaking. Although all six *Metromedia* features need not be present for agency action to be a rule, “an agency determination must be considered an administrative rule when all or most of the relevant features of administrative rules are present and preponderate in favor of the rule-making process.”¹⁴⁴

Applying this law, DOBI’s selection of an EHB benchmark likely constitutes an administrative rule and not informal agency action or an administrative adjudication. The selection of a benchmark plan would be unrelated to the internal management or discipline of DOBI or any other agency and it would not amount to an intraagency or interagency statement. The selection of the plan also would not resolve a legal dispute among specific parties. Rather it would establish a new agency policy that would apply prospectively and generally to individual and small group health insurance plans throughout the State. Because this agency action would include at least most and arguably all of the *Metromedia* factors, it must be considered an

¹⁴⁰ *Id.*

¹⁴¹ *In re Request for Solid Waste Util. Customer Lists*, 106 N.J. 508, 519 (1987).

¹⁴² *Id.*

¹⁴³ *Metromedia, Inc. v. Dir., Div. of Taxation*, 97 N.J. 313, 331-32 (1984).

¹⁴⁴ *Id.* at 331.

administrative rule. As a result, DOBI would need to comply with the procedural requirements for notice and comment rulemaking set forth in the APA¹⁴⁵ to designate an EHB benchmark.

Within DOBI, the Individual Health Coverage Program Board and the Small Employer Health Benefits Program Board have expertise about the individual and small group markets where the EHB requirement will apply and could potentially be involved in the decision making process.¹⁴⁶ The State's Mandated Health Benefits Advisory Commission, which has expertise in evaluating the financial and other impacts of the State's many health insurance mandates, could also serve as a resource.¹⁴⁷

As is discussed more fully below, New Jersey's health insurance Exchange may play a role in determining whether plans offer EHB, as this is one of the requirements for certification as a QHP, as well as in monitoring and enforcement.¹⁴⁸ New Jersey has not yet established a health insurance Exchange, however. While the State may still choose to do so (applications are due November 16, 2012, and the Exchange must be HHS-approved as at least conditionally operational by January 1, 2013),¹⁴⁹ the Exchange is unlikely to be in place in time for its board to be involved in the selection of the benchmark plan.

In a number of states, ad hoc workgroups have been established to recommend a benchmark plan. In Oregon, the governor established, and the Oregon Health Insurance Exchange Corporation Board and the Oregon Health Policy Board chartered, an Essential Health Benefits Workgroup, which has issued recommendations for the State.¹⁵⁰ The Workgroup's members include "approximately 15-20 members from health plans, business, advocates, providers, agents, and other stakeholders[,]"¹⁵¹ as well as "representatives from county health departments . . . and state government."¹⁵² Should New Jersey decide to establish such a workgroup, it would need to consider what areas of expertise it would be helpful for work group members to have, as well as whether there are constituencies which could or should be included.

Even though the workgroup is not likely to conduct an actuarial analysis of the various benchmark options and their impact on premiums itself, a member or members with actuarial expertise might still be advised. The New Jersey health insurance Exchange legislation that was vetoed earlier this year provided that one member of the Exchange board was to be a member

¹⁴⁵ See N.J. Stat. § 52:14B-4(a).

¹⁴⁶ *Id.* §§ 17B:27A-10 and 17B:27A-29.

¹⁴⁷ *Id.* § 17B:27D-3.

¹⁴⁸ 45 C.F.R. § 156.275.

¹⁴⁹ Center for Consumer Information and Insurance Oversight, U.S. Dep't of Health & Human Servs., *Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges*, at 1, 4 (May 16, 2012).

¹⁵⁰ Oregon Health Policy and Research, <http://cms.oregon.gov/oha/OHPR/pages/ehb/index.aspx> (last visited Aug. 2, 2012).

¹⁵¹ Essential Health Benefits Workgroup Charter: March - August 2012, at 1 (Mar. 29, 2012).

¹⁵² Chris Cantrell, States Examine Essential Health Benefits Options, *State Reform* (Apr. 19, 2012), <http://www.statereform.org/how-much-can-you-benchmark-states-examine-essential-health-benefits-options>.

in good standing of the American Academy of Actuaries, and that others have expertise in “(1) individual health care coverage; (2) small employer health care coverage; (3) health benefits plan administration; (4) health care finance; and (5) consumer health care advocacy.”¹⁵³ New Jersey’s Mandated Benefits Advisory Commission is required by statute to include “a medical educator from the University of Medicine and Dentistry of New Jersey whose major field of expertise is the study and evaluation of the cost of health care and health insurance.”¹⁵⁴ Expertise in all of these areas could also be valuable in selecting a benchmark plan.

As explained above, none of the benchmark options is likely to offer habilitative services or pediatric oral and vision benefits to the extent required by the Affordable Care Act. Supplementation, according to rules specific to those categories, will almost definitely be required. Including individuals with expertise relevant to habilitative services and to pediatric oral and vision benefits on the workgroup could therefore be important. In a letter to HHS, the Minnesota chapter of the American Academy of Pediatrics noted that pediatric services in general is an area where there is concern that the benchmark approach to determining essential health benefits will fall short; the Minnesota AAP “strongly encourage[d] participation of physicians who care for children in the review of the adequacy of the benefits set as proposed in the state benchmarks.”¹⁵⁵

The workgroup could also include representatives from constituencies that will be affected by the selection of the benchmark plan. The vetoed health insurance Exchange legislation provided that the advisory committee was to include representatives from

- (a) health insurers or health maintenance organizations offering health benefits plans in this State;
- (b) health service corporations offering contracts in this State;
- (c) insurance producers... ;
- (d) licensed general hospitals;
- (e) licensed long-term care facilities;
- (f) mental health care providers;
- (g) federally qualified health centers;
- (h) licensed physicians;
- (i) licensed nurses;
- (j) small employers;
- (k) public employee unions;
- (l) private sector unions;
- (m) consumer health care advocacy organizations;
- (n) consumer legal advocacy organizations; and
- (o) public health researchers or other academic experts with knowledge and background relevant to the functions and goals of the exchange, including knowledge of the health care needs and health disparities among the diverse communities of this State.¹⁵⁶

¹⁵³ New Jersey Health Benefit Exchange Act, A. 2171 (2012).

¹⁵⁴ N.J. Stat. § 17B:27D-4.

¹⁵⁵ Letter from Marilyn Peitso, President, Minnesota Chapter of the American Academy of Pediatrics & Anne Edwards, Policy Committee Chair, Minnesota Chapter of the American Academy of Pediatrics, to Mike Rothman, Commissioner, Minnesota Department of Commerce, Ed Ehlinger, Commissioner, Minnesota Department of Health, & Cindy Jesson, Commissioner, Minnesota Department of Human Services (June 27, 2012).

¹⁵⁶ New Jersey Health Benefit Exchange Act, A. 2171 (2012).

The State's Mandated Benefits Advisory Commission includes representatives of many of the same constituencies; it also includes "a representative of the New Jersey Dental Association."¹⁵⁷

As is described above, as an alternative to executive agency action, the Legislature could adopt legislation regarding the EHB benchmark selection, either itself designating the benchmark or delegating the task to DOBI. In the latter case, and given the limited time available for the State to make its selection, the Legislature could specify that the agency's benchmark choice would be effective upon adoption, subject to notice and comment rulemaking within a reasonable time period after the effective date of the selection.¹⁵⁸

C. Designation: By What Process

New Jersey also needs to decide what process it will employ to designate its benchmark plan. State Refor(u)m, an online network created by the National Academy for State Health Policy, with funding from the Robert Wood Johnson Foundation, to connect "state health officials looking for information and assistance with their peers and other experts who have relevant resources and experiences to share,"¹⁵⁹ suggests the following steps: (1) form a workgroup; (2) analyze existing state health insurance mandates; (3) assess benchmark plan options; (4) hold a public comment period; and (5) decide on a benchmark plan.¹⁶⁰ According to State Refor(u)m, as of July 23, 2012, 20 states had formed workgroups on essential health benefits, 22 had analyzed their existing mandates, 24 had assessed their benchmark options, 14 were holding or had held a public comment period, and 2 had selected a benchmark plan.¹⁶¹

Regardless of the approach New Jersey decides to take, and regardless of the final decision maker, it will be important to provide for ample input from the public. As mentioned above, State Refor(u)m reports that, thus far, 14 states have held or are holding a public comment period on the benchmark plan decision. Whether it is the legislature or DOBI that makes the decision in New Jersey, there are both formal and informal means to ensure an open and inclusive process. Whether that goal can be achieved given the tight time frame is a concern. The Administrative Procedure Act, which sets forth DOBI's rulemaking authority, provides for 30 days' notice of an agency's intended action.¹⁶² An exception can be made, but

¹⁵⁷ N.J. Stat. § 17B:27D-4.

¹⁵⁸ See, e.g., *id.* § 2A:168-33(h) (permitting Interstate Commission to "promulgate an emergency rule which shall become effective immediately upon adoption, provided that the usual rulemaking procedures provided hereunder shall be retroactively applied to said rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule").

¹⁵⁹ About Us, State Refor(u)m, <http://www.statereforum.org/about> (last visited Aug. 30, 2012).

¹⁶⁰ State Progress on Essential Health Benefits, State Refor(u)m, <http://www.statereforum.org/state-progress-on-essential-health-benefits> (last visited Aug. 2, 2012).

¹⁶¹ *Id.*

¹⁶² N.J. Stat. § 52:14B-4(a)(1).

only where there is “an imminent peril to the public health, safety, or welfare[,]”¹⁶³ which is not apparent here.

D. Designation: Key Considerations

Regardless of who decides, and regardless of how they go about it, the following will be key considerations. First, New Jersey must consider whether and to what extent each of its benchmark plan options covers the State’s health insurance mandates. Selecting a plan that includes the mandated benefits has the twin advantages of (1) “[a]void[ing] additional cost[s]”¹⁶⁴ to [the] state” and (2) “[m]aintain[ing] consistency with [the] will of [the] legislature.”¹⁶⁵ Choosing one of the small group benchmark plan options or the commercial HMO option would achieve the goal of maximizing coverage of mandated benefits.¹⁶⁶ New Jersey’s state employee plans might also cover all of New Jersey’s mandates, but the State will have to explore the possibility that they do not, because only some of New Jersey’s mandates apply to these plans.¹⁶⁷

Even if New Jersey adopts a benchmark plan that includes New Jersey’s mandated benefits, it will have to assume the cost for QHPs of at least two mandates that were adopted after December 31, 2011, the cutoff HHS intends to propose, unless the State’s benchmark includes these benefits independent of the new State mandates.¹⁶⁸ One of these mandates requires coverage of oral anticancer medications “on a basis no less favorable than the plan provides for intravenously administered or injected anticancer medications,” and the other requires coverage of treatment for sickle cell anemia.¹⁶⁹

A second key consideration will be what benefit gaps the various benchmark options have that must be supplemented from other plans. That said, in advising Vermont, Wakely Consulting Group opined that the specific benefits a plan offers within a given category of EHB are less important than the overall level of benefits covered in that category. Wakely writes

¹⁶³ *Id.* § 52:14B-4(c).

¹⁶⁴ Although the cost of state mandates will vary state to state, depending on each states’ mandate requirements and the extent to which the state benchmark covers mandated benefits, Chapin White and Amanda Lechner of the Center for Studying Health System Change contend that the resultant financial liability is likely to be small. See Chapin White & Amanda Lechner, National Institute for Health Care Reform, *State Benefit Mandates and National Health Reform*, at 1 (Feb. 2012). For example, they point to a study conducted in Maryland which found that “Maryland’s liability in 2016 would range from \$10 million to \$80 million—depending on the benchmark plan selected—if the state retained all mandates” because “[a]lmost all of Maryland’s mandates would be included as essential health benefits, regardless of which benchmark plan the state selects.” *Id.*

¹⁶⁵ Colorado’s Essential Health Benefit Benchmark Plan: Introductory Webinar, at 15 (June 2012).

¹⁶⁶ See N.J. Stat. § 17B:27A-1 *et seq.* (individual and small group plans); *id.* § 26:2J-1 *et seq.* (HMOs). See also Alan Monheit, Jasmine Rizzo, Joel Cantor & Jeff Abramo, Rutgers Center for State Health Policy, *Assessing the Impact of Mandated Health Insurance Benefits on Cost and Coverage*, at 3 (Jan. 2007).

¹⁶⁷ Monheit et al., *supra* note 166, at 3.

¹⁶⁸ See *supra* note 59 & accompanying text (citing FAQ, *supra* note 5, at 2).

¹⁶⁹ N.J. Stat. §§ 17B:27A-19.21, 17B:27A-19.22.

that “[s]ince benefits may be substituted within categories as long as they are substantially similar and actuarially equivalent, the relative richness of each plan should be the focus compared to the specific benefits covered.”¹⁷⁰

E. Monitoring and Enforcement

Once a benchmark plan is selected, issuers will develop and individuals will enroll in plans that have been deemed “substantially equal” to the benchmark. Both appeals by individual beneficiaries and formal and informal monitoring and enforcement by advocates and government regulators will be necessary to ensure that the benefits that are covered on paper are paid for in practice.

1. Appeals

The Affordable Care Act requires that

[a] group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum— (A) have in effect an internal claims appeal process; (B) provide notice to enrollees . . . of available internal and external appeals processes . . . ; and (C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.¹⁷¹

In response to federal regulations implementing these requirements, DOBI promulgated revisions to its Health Care Quality Act rules, N.J.A.C. 11:24A-1.1 *et seq.*, and HMO rules, N.J.A.C. 11:24-1.1 *et seq.*, addressing internal claims and appeals as well as external review.¹⁷² The revisions went into effect on February 6, 2012.

New Jersey has set forth in regulations the processes governing challenges to adverse benefit determinations. The regulations define an adverse benefit determination as

a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic,

¹⁷⁰ Julie Peper, Wakely Consulting Group, *Vermont Essential Health Benefits Premium Impact of Benchmark Options*, at 3 (Apr. 30, 2012).

¹⁷¹ 42 U.S.C. § 300gg-19(a)(1).

¹⁷² 44 N.J. Reg. 274 (b) (Feb. 6, 2012).

dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.¹⁷³

The State's regulations require that carriers "establish an appeal process whereby a covered person or a provider acting on behalf of the covered person, with the covered person's consent, may appeal an adverse benefit determination, except where the adverse benefit determination was based on eligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity, within 180 days of receipt of the adverse benefit determination."¹⁷⁴ Carriers offering group health benefits plans must establish an appeal process consisting of an informal internal review (Stage 1), a formal internal review (Stage 2), and a formal external review (Stage 3).¹⁷⁵ Plans that cover individuals can establish a more streamlined process that eliminates Stage 2.¹⁷⁶ At Stage 1, enrollees, or their designated providers, are given "an opportunity to speak, regarding an adverse benefit determination, with the carrier's medical director, or the medical director's designee who rendered the adverse benefit determination,"¹⁷⁷ while at Stage 2, they make their case "before a panel of physicians and/or other providers selected by the carrier who have not been involved in the adverse benefit determination at issue."¹⁷⁸

An enrollee who has exhausted his or her plan's internal appeal process can proceed with a Stage 3 external appeal through the Independent Health Care Appeals Program, which is administered by DOBI.¹⁷⁹ The Appeals Program provides "an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits" that are "covered by the covered person's health benefits plan."¹⁸⁰ The review is conducted by independent utilization review organizations (IUROs) under contract to DOBI.¹⁸¹ Enrollees have the right to sue their insurer in court, usually after exhaustion of IURO proceedings,

¹⁷³ N.J.A.C. § 11:24A-1.2 ; *see also id.* § 11:24-1.2 (same for HMOs).

¹⁷⁴ N.J.A.C. § 11-24A-3.5(a); *see also id.* §§ 11:24-3.7(c) & 11:24-8.4(a) (same for HMOs). DOBI has explained that there are different mechanisms available to appeal decisions that are exempted from review, such as the provider payment arbitration process. *See, e.g., id.* § 11:22-1.8 (requiring carriers to establish internal appeals and external ADR mechanism to resolve disputes relating to payment of claims). While the HMO rules require HMOs to "establish and maintain a system to provide for the presentation and resolution of complaints . . . regarding any aspect of the HMO's health care services, including, but not limited to, complaints regarding quality of care, choice and accessibility of providers, network adequacy and adverse benefit determinations," *id.* § 11:24-3.7 (a), the appeal provisions apply specifically to adverse benefit determinations, *id.* § 11:24-3.7(c).

¹⁷⁵ N.J.A.C. § 11:24A-3.5(e); *see also id.* § 11:24-8.4(a)(1) (same for HMOs).

¹⁷⁶ *Id.* § 11:24A-3.5(e); *see also id.* § 11:24-8.4(a)(2) (same for HMOs).

¹⁷⁷ *Id.* § 11:24A-3.5(j); *see also id.* § 11:24-8.5 (same for HMOs).

¹⁷⁸ *Id.* § 11:24A-3.5(k); *see also id.* § 11:24-8.6(a) (same for HMOs).

¹⁷⁹ *Id.* § 26:2S-11; *see also* N.J.A.C. § 11:24A-5 (HMO group plans); *id.* § 11:24-8.7 (HMO individual plans); *id.* § 11:24A-3.6 (non-HMO plans).

¹⁸⁰ N.J. Stat. § 26:2S-11.

¹⁸¹ *See id.* § 26:2S-12.

for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of the covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.¹⁸²

Among other provisions, New Jersey's regulations also provide for notice to enrollees of the appellate process and the bases for the adverse benefit determination,¹⁸³ permit enrollees an opportunity to respond to the carrier's evidence or rationale,¹⁸⁴ and require carriers to provide "continued coverage of an ongoing course of treatment" during the pendency of the appeal.¹⁸⁵

2. Monitoring and Enforcement

Individual appeals are just one piece of the puzzle; monitoring and enforcement will also be necessary. A number of agencies could potentially be involved in this effort in New Jersey, including the Exchange,¹⁸⁶ DOBI, and the State Attorney General's Banking, Insurance and Insurance Fraud Section which, among other things, brings "civil enforcement actions against licensees and regulated entities."¹⁸⁷

Per DOBI's website, individual inquiries and complaints are handled as follows:

Each inquiry or complaint is assigned to an investigator who reviews the case to ensure that the insurance company and/or producer involved in the matter has complied with applicable insurance statutes and regulations and that the consumer has been treated fairly. In conducting this review, the investigator will contact the insurer or producer and require that the licensee respond to all aspects of the complaint/inquiry. Once the review is complete, the investigator will prepare and send to the consumer a written report of our findings. In

¹⁸² *Id.* §§ 2A:53A-33(a), 34.

¹⁸³ *See, e.g.* N.J.A.C. § 11:24A-3.5(b)-(c), (f), (h); *id.* § 11:24-8.4(a), (c), (e).

¹⁸⁴ *See id.* § 11:24A-3.5(f); *id.* § 11:24-8.4(c). It is notable that while the ACA, as quoted above, requires that an enrollee be able to present evidence and testimony, New Jersey's regulations more generally provide an enrollee with a reasonable opportunity to respond to the carrier's claims.

¹⁸⁵ *See id.* § 11:24A-3.5(i); *id.* § 11:24-8.4(f).

¹⁸⁶ 45 C.F.R. § 155.1010(a).

¹⁸⁷ *See* Banking, Insurance and Insurance Fraud, Division of Law, Office of the Attorney General, Dep't of Law & Public Safety, State of New Jersey, <http://www.nj.gov/oag/law/bi.htm>.

appropriate circumstances, a case will be referred to the Department's Enforcement Unit for further investigation, which may result in the imposition of administrative penalties.¹⁸⁸

The Enforcement Unit, in turn, "is responsible for processing any administrative penalties that may be imposed by the Department for non-compliance with our insurance laws."¹⁸⁹ DOBI's website provides as follows:

As necessary, the Enforcement Unit will work with the Office of the Attorney General in prosecuting persons or entities that allegedly have violated the State's insurance laws. Finally, the Enforcement Unit works closely on issues of common interest with New Jersey's Office of the Insurance Fraud Prosecutor, the New Jersey Bureau of Securities and other State agencies, as well as with the U.S. Department of Labor, the Financial Industry Regulatory Authority (FINRA), other states and law enforcement agencies.¹⁹⁰

New Jersey's monitoring and enforcement efforts will be much more likely to succeed if the State has broad and deep access to data. Commenting on HHS's proposed rule regarding data collection, the American Academy of Pediatrics expressed concern that "the new EHB data collection structure will not make it possible to verify the actuarial equivalence of treatment limits, and in particular, non-quantitative limits."¹⁹¹ The AAP went on to explain that "[t]his flexibility for the plan could result in some plans using non-quantitative limits to reduce access to benefits while still appearing to be actuarially equivalent to the benchmark plan."¹⁹²

VI. Essential Health Benefits Issues for New Jersey to Consider

A. How to Balance Coverage and Cost

The task before New Jersey has been described as "a balancing act between comprehensiveness and cost; the more inclusive the package, the higher the cost."¹⁹³ On the one hand, "[a]s the entity selecting a benchmark and certifying QHPs, states will have a new way, besides benefit mandates, to assure adequate benefits."¹⁹⁴ Many patient advocates have

¹⁸⁸ Division of Insurance - Consumer Protection Services, Dep't of Banking & Ins., State of New Jersey, <http://www.nj.gov/dobi/enfcon.htm>.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ Letter from Robert W. Block, President, American Academy of Pediatrics, to Marilyn A. Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services (July 5, 2012).

¹⁹² *Id.* at 2.

¹⁹³ Amanda Cassidy, Essential Health Benefits Health Policy Brief, HEALTH AFFS., at 1 (Apr. 25, 2012); *see also* IOM, *supra* note 30, *passim* (repeatedly emphasizing, as reflected in the title of the report, the need to balance coverage and cost when defining EHB).

¹⁹⁴ White & Lechner, *supra* note 164, at 6.

focused on this aspect. For example, a December 1, 2011 letter to HHS that 2,400 health care providers and advocates signed onto to protest the IOM report's EHB recommendations highlighted the problem of "enshrin[ing] . . . skimpy plans as the new standard."¹⁹⁵

At the same time, New Jersey must consider the impact of its decisions on premiums and on the health of its individual and small group markets. In a January 31, 2012 letter commenting on HHS' Bulletin, former DOBI Commissioner Thomas B. Considine contended that the benchmark plan will inevitably be richer, and therefore potentially less affordable, than plans available on the market now, because of the ban on annual and lifetime limits and because any of the benchmark options is likely to need supplementation to cover all ten categories of EHB.¹⁹⁶

The health insurer Cigna has opined that if "[d]efined too broadly or too vaguely, costs will increase and exchange coverage may be unaffordable."¹⁹⁷ Ensuring that the essential health benefits package is affordable is particularly important in light of the need for the relatively young and healthy to participate in the health insurance market. The Oregon Essential Health Benefits Workgroup concluded that while expensive benefits such as alternative medicine, adult dental, and bariatric surgery "are extremely valuable to some, lowering costs while still providing access to 'essential' services will optimize participation in and outside the Exchange."¹⁹⁸ The Workgroup noted that "[h]ealth insurers may still offer these benefits in their more comprehensive benefits packages or as riders to Oregonians that need them."¹⁹⁹

B. Coverage Concerns: Prescription Drugs

HHS' proposal that plans be permitted to select the specific drugs they offer in their formularies, as long as they cover at least one drug in each category or class of drugs included in the benchmark,²⁰⁰ has attracted controversy. Even though HHS has compared its intended

¹⁹⁵ An Open Letter to Secretary Sebelius and President Obama regarding the Institute of Medicine's recommendations on the Essential Benefits under the 2010 Health Reform Law (Dec. 1, 2011), *available at* <http://www.pnhp.org/news/2011/december/more-than-2400-doctors-nurses-and-health-advocates-denounce-institute-of-medicine>.

¹⁹⁶ Letter from Thomas B. Considine, Commissioner, New Jersey Dep't of Banking and Ins., to Kathleen Sebelius, Secretary, U.S. Dep't of Health & Human Servs. (Jan. 31, 2012), *available at* http://www.state.nj.us/dobi/division_insurance/pdfs/nj_essentialhealthbenefitscomments.pdf [hereinafter Considine Letter].

¹⁹⁷ Cigna, Essential Health Benefits (Apr. 2, 2012), http://www.cigna.com/assets/docs/about-cigna/loR%20Advocacy%20Papers/841321_a_EssentialHealthBenefits.pdf.

¹⁹⁸ July 3, 2012 Memorandum from The Essential Health Benefits Workgroup to Oregon Health Insurance Exchange Corporation Board and Oregon Health Policy Board regarding Essential Health Benefits Workgroup Final Recommendation, at 2, *available at* <http://cms.oregon.gov/oha/OHPR/EHB/docs/FinalRecLetter.pdf> [hereinafter Oregon Workgroup Letter]. Cigna notes that "[i]f the EHB definition makes plans unaffordable, insurers will face increased adverse selection risk in individual and small group markets." Cigna, *supra* note 197, at 2. The company adds that "[e]mployees sent to the individual exchange may opt to pay the penalty rather than be insured." *Id.*

¹⁹⁹ Oregon Workgroup Letter, *supra* note 198, at 2.

²⁰⁰ Bulletin, *supra* note 2, at 12-13.

flexibility regarding prescription drug coverage to “the flexibility permitted in Medicare Part D,”²⁰¹ in fact its EHB proposal is less generous than Medicare Part D, which requires that formularies “include within each therapeutic category and class of Part D drugs at least two Part D drugs that are not therapeutically equivalent and bioequivalent[.]”²⁰² CMS also has the authority to “require more than two drugs for particular categories or classes if additional drugs present unique and important therapeutic advantages in terms of safety and efficacy, and their absence from the sponsor’s formulary would substantially discourage enrollment by beneficiaries with certain disease states.”²⁰³ Finally, “Part D sponsor formularies must include all or substantially all drugs within the immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes.”²⁰⁴ HHS makes clear in the Bulletin that it does “not intend to adopt the protected class of drug policy in Part D.”²⁰⁵

Professor Kenneth Thorpe has opined that HHS’s proposal that plans be required to cover at least one drug per category is “unnecessarily restrictive” and “would be catastrophic[.]” because “[m]edicines are not interchangeable.”²⁰⁶ In its comments on HHS’ proposed data collection rule, the Colorado Consumer Health Initiative makes the argument that the Affordable Care Act requires that the EHB package be comparable to a typical employer plan, which means that the EHB package will have to cover “a broad range of drugs . . . within each category or class.”²⁰⁷

Insurers, on the other hand, seek to maximize plan flexibility with respect to prescription drug coverage. They strongly objected to HHS’ proposal that plans submit data on prior authorization and step therapy requirements, because of the associated burden but also because they feared that these would be incorporated into the benchmark. In response to the negative comments it received, HHS backed off its proposal. The final regulation requires that plans submit information on “[d]rug coverage[.]” which HHS explains means a “list of covered

²⁰¹ *Id.* at 12.

²⁰² 42 C.F.R. § 423.120(b)(2)(i).

²⁰³ MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL, ch. 6, § 30.2.1, *available at*

<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf>.

²⁰⁴ *Id.* at § 30.2.5.

²⁰⁵ *Id.* at 13 n. 34.

²⁰⁶ Kenneth Thorpe, “Determining ‘Essential’ Health Benefits,” *The Hill’s Congress Blog* (June 20, 2012 1:46 P.M. EST). Professor Thorpe explains that “[o]ne patient with a health condition may get better results from a particular drug than another with the same illness. Physicians regularly try different medications and dosages with their patients to find the best solution to treat their symptoms, sometimes even turning to a ‘cocktail’ comprised of multiple medicines. That would no longer be feasible if the federal government allow health plans to only pay for one prescription medicine.” *Id.*

²⁰⁷ Colorado Consumer Health Initiative, Comments to the Dep’t of Health and Human Servs., re: Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, at 3 (July 5, 2012), *available at* <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0071-0036>.

drugs.”²⁰⁸ Kaiser Permanente has registered an objection to even that, explaining that “[s]ome plans have broad formularies with higher degrees of utilization management, while others have narrow formularies but easier access to medically necessary formulary exceptions.”²⁰⁹ Kaiser argues that instead of requiring plans to “modify their formularies to match the benchmark plan’s formulary in order to comply with EHB requirements[,]” HHS should rely on state-level regulation to ensure that enrollees have access to the drugs they need.²¹⁰

Because HHS has not yet issued final regulations on EHB, it is not yet clear what decisions will be made for New Jersey and what will be left to state-level regulation. The State will almost definitely have some role to play mediating between the desires of patients, providers, and pharmaceutical companies, on the one hand, and insurers on the other.

C. Coverage Concerns: Habilitative Care

HHS’ proposal with regard to coverage of habilitative care has also been a source of controversy. As explained above, the first option proposed by the agency would be to require that plans offer habilitative services “at parity with rehabilitative services[.]”²¹¹ Former Commissioner Considine argued in his January 31, 2012 letter to HHS that “[w]hile parity could provide some ability to control costs, it artificially constrains coverage within parameters really designed for recovering lost function.”²¹² Former Commissioner Considine highlighted the fact that devices used for rehabilitation are very different from those used for habilitation.²¹³

Alternatively, HHS is considering allowing plans to decide which habilitative services to cover. HHS then would define habilitative services after evaluating the choices made by the plans.²¹⁴ This approach, too, raises concerns, namely that habilitative services will not be provided consistently across plans or at a level that comports with the Affordable Care Act. Interestingly, at least one major insurer, Cigna, has argued against allowing plans to define habilitative services for themselves. Cigna told HHS “that a consistent definition of habilitative services should be applied across all plans to avoid consumer confusion when comparing plans

²⁰⁸ Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42,658, 42,660 (July 20, 2012).

²⁰⁹ Letter from Anthony A. Barrueta, Senior Vice President, Government Relations, Kaiser Permanente to Centers for Medicare and Medicaid Services re: Patient Protection and Affordable Care Act; Data Collection To Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans [CMS-9965-P], at 4 (July 5, 2012), *available at* <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0071-0054>.

²¹⁰ *Id.*

²¹¹ Bulletin, *supra* note 2, at 11; *see also* FAQ, *supra* note 5, at 2 (“A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.”).

²¹² Considine Letter, *supra* note 196, at 3.

²¹³ *See id.*

²¹⁴ Bulletin, *supra* note 2, at 11.

and to ensure a level playing field among Qualified Health Plans.”²¹⁵ Oregon’s workgroup announced in a July 3, 2012 memorandum that it prefers the parity approach to the plan-by-plan approach, because of the complexities that would be introduced by the requirement that plans report on their habilitative services coverage to HHS.²¹⁶

²¹⁵ Letter from Edward P. Potanka, Vice-President and Assistant Chief Counsel, Cigna, to Centers for Medicare and Medicaid Svcs. Re CMS-9965-P, at 2 (July 3, 2012), *available at* <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0071-0013>. As the IOM report noted, however, there is no apparent consistent definition of habilitative services in the small and individual group markets. Instead, as HHS noted in the Bulletin, *see supra* note 73 (citing Bulletin, *supra* note 2, at 11), insurers employ different definitions with varying degrees of specificity and scope. WellPoint, for example, acknowledged that habilitation is a broad category, and that “there is likely to be variation in what an insurer defines as habilitative.” IOM, *supra* note 30, at 189, Appendix C, Table C-4, n.dd. Although WellPoint does not have a specific habilitation benefit or exclusion, there are habilitative services that may be covered by its plans. It defines “habilitative care as a category that includes services such as (1) early intervention; (2) autism mandates (i.e., improving language skills); (3) congenital defect mandates; and (4) home health care services provided by a licensed home health agency (i.e., skilled nursing and physical therapy), not services such as meal preparation, bathing, and medication management.” *Id.* at 189, Appendix C, Table C-4, n.dd. Cigna, in contrast, recommends that HHS adopt a definition of habilitative services that is restricted to services “designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental timeframe.” Potanka letter, *supra* note 215, at 2. The IOM report notes that in a floor statement Representative Bill Pascrell Jr. of New Jersey called for a broad interpretation of medical necessity for rehabilitative and habilitative services because they include “items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning as a result of an illness, injury, disorder or other health condition” and “training of individuals with mental and physical disabilities to enhance functional development.” IOM, *supra* note 30, at 97 & n.16; *cf.* 42 U.S.C. § 1396n(c)(5)(A) (defining habilitation services under Medicaid to include “services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings,” including “prevocational, educational, and supported employment services,” but not including “special education and related services” or “vocational rehabilitation services” that are otherwise available to the individual); 42 C.F.R. § 440.40(b)(1)-(2) (defining early and periodic screening and diagnosis and treatment (EPSDT) to include not only “[s]creening and diagnostic services to determine physical or mental defects in beneficiaries under age 21” but also, among other things, “[h]ealth care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered”); *see also* IOM, *supra* note 30, at 229-30, Appendix G (noting that Medicaid’s EPSDT program coverage rules “are more inclusive of concepts applicable to the [ACA’s] category of habilitation” and summarizing different definitions of medical necessity for Medicaid adopted in different states). *Compare id.* at 61 (“Habilitative services are distinct from rehabilitation, in that they are designed to help a person first attain a particular function vs. restoring a function.”), *with id.* at 74-75 (“Insurers make distinctions about whether services or specific items are nonmedical and whether that alone is a sufficient reason for exclusion. For example, while interventions such as teaching Braille and American Sign Language can improve functioning and productivity in persons who are blind or hearing impaired, they have been classified as primarily educational and not part of health care delivery. . . . The introduction of habilitation as a category for the EHB raises questions about where to draw the line between habilitation and social/educational services. . . . As one of its criteria for the EHB, the committee concludes that included benefits should be a *medical* service or item, not serving primarily a social or educational function. This conclusion does not preclude coverage of some educational or support services . . . [,] supported by a sufficient evidence base of effectiveness and promoting a health gain to justify the cost. ”). *See generally* New York State Comments on December 16, 2011 Essential Health Benefits Bulletin, at 3 (urging that “maintenance of function” be included in the definition of habilitative services), *available at* http://www.healthcarereform.ny.gov/docs/nys_comments_ehb_bulletin.pdf.

²¹⁶ Oregon Workgroup Letter, *supra* note 198, at 1.

In former Commissioner Considine’s letter, he argued that habilitative services and devices should be decided at the plan level but that plan discretion should be cabined by a market-wide definition of habilitative services to be promulgated by the State’s individual and small employer boards.²¹⁷ In a report prepared for Arizona, Mercer recommended a similar approach, arguing that “the State should seek to establish parameters regarding minimum services or further define ‘habilitative’ thereby ensuring that all habilitative service packages being reported to HHS remain representative of typical individual and small group market offerings.”²¹⁸

As with prescription drug coverage, it is not yet clear which decisions HHS will make and which will be left to New Jersey with regard to habilitative services. Regardless of which approach is taken, monitoring and enforcement will be particularly important. While small group plans in New Jersey do have some relevant experience as a result of the mandate requiring that they cover certain specified therapies for children with autism and other developmental disabilities,²¹⁹ they do not have a track record of covering habilitative services more generally. The IOM committee believed that independent external appeals will be a critical “step in protecting the rights of patients”²²⁰ It highlighted the role for federal and state regulators “to document [at the plan level] what services are offered or excluded, particularly in the area of habilitation.”²²¹ To facilitate monitoring and learning from implementation of this check, the report suggested “standardized data collection and evaluation of appeals;” “examination of clinical policies;” and “[t]ransparency and disclosure of data and rationale on these decisions.”²²² DOBI could implement each of these recommendations with respect to New Jersey carriers.

D. Substitution

As outlined in Section IV.B. above, HHS intends to permit issuers to make substitutions to the state benchmark plan. This flexibility creates room for innovation in plan design that may give consumers more choices that align with their particular needs. But it also will make it harder for consumers to compare plans and make informed purchasing choices among options. Flexibility to make substitutions to the benefits in the state benchmark also can increase the threat of a species of adverse selection that Tom Baker has referred to as risk classification by design – separating “people into different risk pools through the design of health plans that appeal differently to people in ways that correlate with health status, challenging the core non-

²¹⁷ Considine Letter, *supra* note 196, at 3.

²¹⁸ Mercer, Essential Health Benefits Arizona Department of Insurance, at 10 (June 10, 2012), *available at* <http://www.azgovernor.gov/hix/documents/Grants/EHBReport.pdf>.

²¹⁹ N.J. Stat. § 17B:27A-19.20.

²²⁰ IOM, *supra* note 30, at 99.

²²¹ *Id.* at 75.

²²² *Id.* at 99.

discrimination value embodied in the [ACA].”²²³ The degree of risk created by flexibility will depend on the parameters HHS sets for substitutions and the degree of monitoring for compliance with these boundaries to ensure substitutions do not become a trap door that undermines the foundations of EHB. Without adequate safeguards, substitutions can disproportionately affect certain groups, such as the chronically ill or disabled. It thus is critical to craft and police appropriate boundaries for substitution to preserve the intent of EHB.

Although HHS has not proposed regulations for EHB, its Bulletin and FAQ on EHB point to standards established in the SCHIP regulations as guideposts for cabining substitution in the EHB context. Specifically, HHS intends to require that substitutions of coverage of benefits within the 10 categories must “be actuarially equivalent, using the same measures defined in [S]CHIP,” citing 42 C.F.R. § 457.431 from the SCHIP regulations.²²⁴ Like the proposed EHB benchmark approach, SCHIP permits states to craft a benchmark-equivalent plan based on a menu of potential benchmarks identified by HHS in 42 C.F.R. § 457.420.²²⁵ To gain approval of a benchmark-equivalent plan, Section 457.431 requires the state to submit a report to CMS prepared by a member of the American Academy of Actuaries,²²⁶ containing an actuarial opinion that the aggregate actuarial value²²⁷ of the health benefits coverage of the benchmark-equivalent plan “is at least actuarially equivalent to the coverage under one of the benchmark packages.”²²⁸

²²³ See Tom Baker, Institute for Law and Economics, University of Pennsylvania Law School, Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act, Research Paper No. 11-03, at 28 (Feb, 2011), available at <http://ssrn.com/abstract=1759366>. This threat is especially high if HHS permits substitutions between the 10 mandatory ACA categories, as such substitutions would threaten to undermine the meaningfulness of coverage in the substituted categories and, in doing so, the ACA’s intent to guarantee balanced coverage in all 10 categories. Although HHS has not yet expressly withdrawn its statement in the Bulletin that it is considering permitting cross category substitutions, it also has only referred to in-category substitutions in recent guidance. See *supra* note 86 & accompanying text. Thus, for purposes of this Brief, it is assumed that HHS only is permitting substitutions within the 10 ACA categories and not across categories.

²²⁴ Bulletin, *supra* note 2, at 12 & n.33; see also FAQ, *supra* note 5, at 3 (stating that “a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in SCHIP regulations at 42 C.F.R. § 457.431, and provided that substitutions would not violate other statutory provisions”).

²²⁵ 42 C.F.R. § 457.430. As an alternative to benchmark or benchmark-equivalent coverage, the SCHIP regulations also permit states to choose to offer existing comprehensive state-based coverage in accordance with 42 C.F.R. § 457.440 or Secretary-approved coverage in accordance with 42 C.F.R. § 457.450. See *id.* § 457.120.

²²⁶ *Id.* § 457.431.

²²⁷ See generally Actuarial Value and Cost-Sharing Reductions Bulletin, at 2 (Feb. 24, 2012) (“Actuarial value (AV) is a measure of the percentage of expected health care costs a health plan will cover and can be considered a general summary measure of health plan generosity.”), <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>; Jean Hearne & Jennifer A. Neisner, Congressional Research Service, The State Children’s Health Insurance Program: Guidance on Frequently Asked Questions, 97-926 EPW, at 9 (updated Mar. 20, 1998) (“The actuarial value of a set of benefits is the dollar value of those benefits.”), <http://www.policyarchive.org/handle/10207/bitstreams/481.pdf>.

²²⁸ 42 C.F.R. § 457.430(a); cf. *id.* §§ 440.330, 440.335, & 440.340 (establishing similar actuarial equivalence requirement for Medicaid benchmark-equivalent coverage). If the SCHIP benchmark plan covers prescription drugs, mental health services, vision services, or hearing services, “then the actuarial value of the coverage of each

HHS also intends to permit issuers to impose non-dollar limits that are actuarially equivalent to annual or lifetime limits on EHB that were stripped from the benchmark as required by Section 2711 of the PHSA.²²⁹ As Tim Jost has noted, “[t]his will substantially undermine the dollar limit prohibition [in Section 2711].”²³⁰

The SCHIP regulations do not define actuarial equivalence, but the American Academy of Actuaries defines it as “a general term used to describe two or more benefit plan designs that have approximately the same value.”²³¹ While actuarial equivalence calculations typically include cost-sharing features and differences in services covered, they often do not include out of network benefits or provider network differences.²³² Indeed, Section 457.431 itemizes a number of requirements for the actuarial analysis, including that it use a standardized set of utilization and price factors and a standardized population and “take into account the ability of a State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage,” but not take into account any differences in coverage based on the method of delivery or means of cost control or utilization used.²³³ As a result, two plans can be actuarially equivalent even though they cover different benefits and have different cost-sharing arrangements,²³⁴ which makes the plans difficult to compare.

of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the value for such a category in the benchmark plan” *Id.* § 457.430(c)(2).

²²⁹ FAQ, *supra* note 5, at 4; *supra* notes 87-88 & accompanying text.

²³⁰ Timothy Jost, “Implementing Health Reform: Essential Health Benefits And Medical Loss Ratios”, Health Affairs Blog (Feb. 18, 2012), <http://healthaffairs.org/blog/2012/02/18/implementing-health-reform-essential-health-benefits-and-medical-loss-ratios/>.

²³¹ American Academy of Actuaries, *Critical Issues in Health Reform: Actuarial Equivalence*, at 1 (May 2009), http://www.actuary.org/pdf/health/equivalence_may09.pdf; *see also* American Academy of Actuaries, *Health Reform Implementation: Understanding the Terminology*, at 1 (2010) (“Actuarial values depend on the plan’s cost-sharing requirements as well as the specific services that the plan covers. Two or more plans that have the same actuarial value are referred to as being actuarially equivalent.”). *Cf.* 26 C.F.R. § 1.401(a)(4)-12 (“Actuarial equivalent. An amount or benefit is the actuarial equivalent of, or is actuarially equivalent to, another amount or benefit at a given time if the actuarial present value of the two amounts or benefits (calculated using the same actuarial assumptions) at that time is the same.”); Amanda Cassidy, *Health Policy Brief: Essential Health Benefits*, Health Affairs, at 2 (Apr. 25, 2012) (explaining that actuarial equivalence for purposes of issuer substitution means “that the benefits [offered] are of approximately the same value in each of the 10 required categories [to those in the benchmark plan]”).

²³² American Academy of Actuaries, *Critical Issues*, *supra* note 232, at 1; *see also* Chris L. Peterson, *Congressional Research Service, Setting and Valuing Health Insurance Benefits*, 7-5700, R40491, at 1 (Apr. 6, 2009) (noting that actuarial values generally do not take into account several factors that can have significant impacts on premiums, including, among others, the health of those enrolled, the provider network, out-of-network benefits, and utilization management tools), <http://www.policyarchive.org/handle/10207/bitstreams/19244.pdf>.

²³³ 42 C.F.R. § 457.431.

²³⁴ Peterson, *supra* note 232, at 3; *see also* Hearne & Neisner, *supra* note 227, at 10 (offering the example of a plan that covers extensive hospital care but no dental or vision coverage that could be actuarially equivalent to a plan with limited hospital care coverage but high value dental and vision coverage).

In addition to looking at whether the specific substitutions are actuarially equivalent, HHS intends to require that plans offer benefits that are substantially equal in both the scope of benefits offered and any limitations on the benefits offered in the benchmark plan, such as visit limits.²³⁵ HHS has described this requirement as being “the same equivalency standard that applies to plans under [S]CHIP,” citing 42 C.F.R. § 457.420.²³⁶ But Section 42 C.F.R. § 457.420 simply defines benchmark coverage as coverage that is substantially equal to the coverage provided in one of three existing plans in the market, the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to federal employees, a health benefits plan generally available to state employees, and the largest insured commercial, non-Medicaid HMO plan by enrollment.²³⁷ This regulation does not define or provide factors to take into consideration in determining if benefits are substantially equal.²³⁸

At bottom, “actuarial analysis is inherently an estimation process and hence is somewhat inexact.”²³⁹ Although it can help assure that a plan meets a minimum threshold of coverage, actuarial equivalence does not necessarily help consumers select which plan offers the best coverage for their particular health care needs.²⁴⁰ The variation in coverage that results from actuarially equivalent substitution also makes it harder for consumers to compare plans. In addition, the flexibility to make substitutions to the EHB benchmark increases the chance for risk selection by design even when the substitutions are actuarially equivalent.²⁴¹ Asking whether plans are substantially equal, especially without factors to guide the analysis, similarly is inexact. Neither analysis seems to take into consideration how substitutions affect sub-populations, like the disabled or elderly, even though the ACA requires the definition of EHB to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups,”²⁴² and prohibits benefit

²³⁵ Bulletin, *supra* note 2, at 12 & n.32; FAQ, *supra* note 5, at 3.

²³⁶ Bulletin, *supra* note 2, at 12 & n.32.

²³⁷ 42 C.F.R. § 457.420.

²³⁸ Cf. 34 C.F.R. § 106.34(b)(3) (listing factors that the Department of Education “will consider, either individually or in the aggregate as appropriate, in determining whether classes or extracurricular activities are substantially equal”); *id.* § 668.22(l)(5) (providing specific definition for when a school term is substantially equal in length); *id.* § 682.604(c)(7)(ii) (same regarding loan terms); 42 C.F.R. § 457.450(g) (requiring “a benefit-by-benefit comparison which demonstrates that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan” to establish that coverage under a group health plan purchased by the state is substantially equivalent to or greater than coverage under a benchmark health benefits plan such that it may be approved as a Secretary-approved coverage without actuarial analysis).

²³⁹ American Academy of Actuaries, Critical Issues, *supra* note 231, at 4.

²⁴⁰ *Id.* at 2-3; Peterson, *supra* note 232, at 3.

²⁴¹ American Academy of Actuaries, Critical Issues, *supra* note 231, at 3 (noting that “even among actuarially equivalent plans, some plans may have features that appeal to high-risk individuals, and others may have features that appeal to low-risk individuals”).

²⁴² 42 U.S.C. § 18022(b)(4)(C).

design “that discriminates against individuals because of their age, disability, or expected length of life.”²⁴³

Given the lack of precision in the standards HHS intends to propose in the EHB context, it becomes all the more critical to monitor how issuers substitute benefits, including non-dollar limits, to ensure this flexibility does not undermine the intent of the ACA. It is not clear from the regulatory guidance who or what will be monitoring issuers to ensure substitutions are actuarially equivalent, that benefit plans are substantially equal to the benchmark, and that the substitutions do not violate the ACA’s guiding principles of maintaining an appropriate balance among the 10 categories, avoiding discrimination against individuals because of their age, disability, or expected length of life, and taking into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

There are three primary candidates to fulfill this oversight function – HHS, DOBI, or the health insurance Exchange that is supposed to be operating in New Jersey by 2014. Although the SCHIP regulations suggest that HHS evaluates whether SCHIP benchmark-equivalent plans are actuarially equivalent, HHS has not indicated that it will be taking the lead to do robust review of plan substitutions in EHB. This review would need to be at the plan level, since each plan sold in the individual and small group markets is permitted to make these substitutions. It would seem that this would be a demanding task for an already burdened agency.

DOBI, on the other hand, already evaluates each insurance product to decide whether to license it to be sold in New Jersey markets. It thus may make more sense to task DOBI with evaluating substitutions for compliance with EHB as part of the State licensing process.²⁴⁴

Another alternative is to empower the Exchange in New Jersey to monitor substitutions for compliance with EHB provisions. The Exchange has an independent obligation to determine whether making a given health plan available through the Exchange “is in the interest of the qualified individuals and qualified employers.”²⁴⁵ The Exchange thus could use this standard to evaluate plan substitutions and refuse to approve a plan as a QHP if it is not substantially equal to the benchmark, if its substitutions are not actuarially equivalent, or if it otherwise does not comply with the ACA. Because EHB applies outside of the Exchange, however, the State would need to authorize the Exchange to oversee more than just plans seeking to be sold through it. While there does not appear to be a legal impediment to granting the Exchange the responsibility to monitor more than QHPs, as long as it is regulating plans that are otherwise

²⁴³ *Id.* § 18022(b)(4)(B); *see generally* FAQ, *supra* note 5, at 3 (noting that “any scope and duration limitations in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design”).

²⁴⁴ *See, e.g.* Letter from Toby Douglas, Director, California Dep’t of Health Care Servs., *et al.*, to Hon. Kathleen Sebelius, Secretary, U.S. Dep’t of Health & Human Servcs., at 3 (Jan. 30, 2012) (arguing that states “should be responsible for defining and enforcing ‘actuarial equivalence’ of benefits within and across categories.”), http://www.mrmib.ca.gov/mrmib/Agenda_Minutes_021512/Agenda_Item_10_Healthcare_Reform_Under_the_Affordable_Care_Act.pdf.

²⁴⁵ 45 C.F.R. § 155.1000(c)(2).

amenable to State regulation, it may be inefficient to do so because issuers would have to wait until the Exchange evaluated plans before offering them outside of the Exchange. It also may not be politically viable to grant Exchanges oversight over more than QHPs.

Unless the expected EHB regulations preempt states from monitoring EHB implementation, New Jersey should evaluate the relative strengths and weaknesses of requiring DOBI, the Exchange, or some other independent entity in New Jersey to carefully monitor substitution to ensure it does not frustrate the goals of EHB in the name of flexibility.

Regardless what level of government is responsible for monitoring substitutions, there is concern that flexibility makes it “hard to imagine . . . how plan compliance will ever be monitored . . .”²⁴⁶ California thus has argued to HHS that states should not be preempted from limiting issuers’ ability to make substitutions to EHB benchmarks.²⁴⁷ Nothing in the federal EHB guidance released to date suggests that states may restrict issuer flexibility to vary EHB benefits beyond the limits contained in the Bulletin and FAQ. Much will depend on how the expected EHB regulations are drafted. It is possible that courts would find that state efforts to restrict flexibility expressly provided for in the regulations are preempted based on field or conflict preemption.²⁴⁸ Given that Congressional purpose “‘is the ultimate touchstone’ in every pre-emption case,”²⁴⁹ however, it is possible that courts would find that state efforts to restrict substitutions are in service of, and not in tension with, Congress’s intent in enacting the EHB provisions, and thus not preempted.

Even if states choose not to or are preempted from restricting substitution of EHB, more specific data collection and disclosure about plan design could help shed light on issuer practices and facilitate meaningful evaluation of plan design and comparison among plans. The proposed data collection rule would have required the three largest small group products to provide information about nonquantitative limits on benefits, such as prior authorization and step therapy requirements, in their largest plans by enrollment.²⁵⁰ This information could have provided a fuller picture of plan design decisions that appeal to some consumers more or less than others and thus could impact plan selection. But HHS omitted nonquantitative limits on benefits from its final definition of treatment limitations, finding that such data “are not necessary for benchmark plan purposes”²⁵¹ HHS also refused commentators’ request to collect additional information, “such as data on exclusions, medical necessity, habilitative services, cost-sharing (including premiums and co-pays), additional drug data, additional data

²⁴⁶ Jost, *supra* note 230; *see also* Letter, *supra* note 244, at 3 (“State regulators are concerned that carrier flexibility in this area will seriously undermine their ability to effectively monitor and enforce carrier compliance with essential health benefits.”).

²⁴⁷ *See* Letter, *supra* note 244, at 3.

²⁴⁸ *See, e.g., Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707 (1985).

²⁴⁹ *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963)).

²⁵⁰ EHB Data Collection PR, *supra* note 36, 77 Fed. Reg. at 33,135.

²⁵¹ EHB Data Collection FR, *supra* note 40, 77 Fed. Reg. at 42,660.

on treatment limits, and a more extensive list of benefits.”²⁵² New Jersey could consider requiring issuers to provide this greater detail regarding the benefits they provide under different plans to make it easier for the State, and ultimately consumers, to compare plan coverage. Such state regulation arguably does not prevent the application of the ACA and should not be preempted.

It is also notable that a part of the SCHIP regulations that is not specifically cited in the EHB Bulletin or FAQ requires states to develop methods for assuring access to, and the quality and appropriateness of, care.²⁵³ Because such a provision should reinforce the ACA requirements concerning EHB, states should not be preempted from adopting a similar provision to serve as an additional check on the risks flexibility introduces, if the EHB regulations do not incorporate a similar provision.

VII. Conclusion

The Affordable Care Act’s goal of extending health coverage incorporates important corollary goals: that health coverage extend to services essential to serve the needs of those covered while costs are responsibly contained. Defining and ensuring the provision of “essential health benefits” will be a difficult and extended process in which New Jersey will play a central role. The first task facing New Jersey will be selecting and appropriately supplementing a benchmark plan, on which most individual and small group plans will be modeled after 2014. The task could be performed through regulation or legislation, and may most effectively be accomplished through the coordinated efforts of the Legislature and Executive.

Evaluating and monitoring plans’ provision of essential health benefits will be an important ongoing project for government, carriers, employers, and consumers. New Jersey law contains appeals processes by which disputes can be resolved. Review of claims filed in these processes, survey of plan members’ experiences in accessing care, and auditing of plan decisions, including medical necessity decisions, will permit appropriate evaluation of the extent to which the goal of assuring the coverage of essential benefits is being met.

Effort spent on getting the “essential health benefits” process right will be effort well spent. It is through this effort that New Jersey can ensure that the extension of health coverage does not embody an empty process – a card connoting health coverage that does not deliver what the plan member needs. It is through attention to this process that New Jersey can instead assure that coverage will lead to necessary and appropriate care.

²⁵² *Id.*

²⁵³ See 42 C.F.R. § 457.495.

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