STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Earl Ray Tomblin
Governor

MARCH 2013

Michael D. Riley
Insurance Commissioner

WEST VIRGINIA INFORMATIONAL LETTER

NO. 186

TO: All Insurance Companies Authorized to Sell Health Insurance Plans in West Virginia's Small Group and Individual Markets

RE: Providing Essential Health Benefits in West Virginia

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were signed into law. The two laws are collectively referred to as the Affordable Care Act ("ACA"). Among the many reforms in the ACA, as part of an amendment to the Public Health Services Act ("PHSA"), the ACA requires all qualified health plans ("QHP's") as well as all health care plans sold in the United States in the small group or individual markets to include "essential health benefits" ("EHB"), defined as ten (10) categories of benefits. (See ACA §2707 codified at 42 USC §300gg-6; ACA §1301 codified at 42 USC §18021). Aside from the ten basic categories, discretion on how to define EHB was left to the U.S. Department of Health and Human Services ("HHS"). The HHS ultimately used a "benchmark" approach, permitting each state to select a benchmark plan from various options of plans offered in the state or federal plans. West Virginia did not specifically select a benchmark, therefore, under the HHS procedure, West Virginia's largest small group plan, the "Highmark Blue Cross BlueShield West Virginia $1000 Deductible Super Blue Plus 2000 PPO Plan" was selected. This plan's selection as West Virginia's benchmark plan is set forth in a final rule the HHS promulgated on EHB. (See 45 CFR §§147, 155 and 156.)

The purpose of this informational letter is to provide all health insurance carriers in West Virginia who issue policies in the QHP[1], small group and individual market some more specific guidance as to how to comply with the ACA EHB requirement based on West Virginia's benchmark. The final EHB rule referenced above clarifies that for a health care policy to be deemed to provide EHB, it must generally "provide benefits that…[a]re substantially equal to the EHB benchmark plan including: (i) Covered benefits; [and] (ii) Limitations on coverage including coverage of benefit amount, duration and scope…." See 45 CFR §156.115. Following the publication of this final rule, the West Virginia Offices of the Insurance Commissioner ("OIC") had communication with officials from the HHS to seek clarity on what "substantially equal" means. The HHS clarified that the purpose of the language was to permit some flexibility among various plans as compared to the benchmark within the states' discretion. The HHS also clarified, however, that the "starting point" for EHB was the actual language of the benchmark policy, not just the general guidelines of the benchmark set forth in the EHB rule (the EHB rule has a matrix of each state's benchmark with some information as to each).

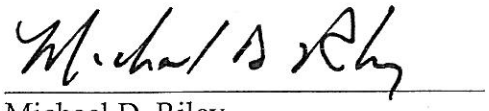
[1] Until 2017, all QHP's are in the individual or small group market; however large group plans may enter the QHP market in 2017.

As such, the OIC directs all health insurance carriers required to provide EHB in West Virginia to use the benefits as outlined in the "Highmark Blue Cross BlueShield West Virginia $1000 Deductible Super Blue Plus 2000 PPO Plan" Certificate of Coverage, attached to this letter as Appendix 1, as a starting point for determining how to provide EHB. However, pursuant to the goal of flexibility embedded in the term "substantially equal", some deviation is permitted. For example, a carrier may want to slightly alter the number of visits or treatments permitted within a certain benefit type. As long as the deviation is deemed by the OIC to be "substantially equal", it would be permissible. The OIC will ultimately address whether deviations from the benchmark are "substantially equal" on a case-by-case basis. Carriers may be asked to provide additional justification[2] for deviating significantly from the benchmark.

In addition to the above, carriers who issue policies that must be EHB compliant need to also be aware of the following "backfills" (benefits that had to be "filled in" as the West Virginia benchmark plan did not contain them) for the West Virginia benchmark:

- Pediatric Dental Benefits – the West Virginia CHIP schedule of benefits needs to be provided consistent with the "WV Children's Health Insurance Program Dental Provider Guide 2012-2013", attached to this letter as Appendix 2;
- Pediatric Vision Benefits – the vision benefits available to children under the Blue Cross-Blue Shield Federal Employee Program plan need to be provided consistent with the "FEP Blue Vision" document, attached to this letter as Appendix 3;
- Habilitative Benefits – These benefits need to be provided consistent with OIC's Informational Letter No. 184, published on March 28, 2013;
- Infertility Treatment – These benefits need to be provided on a limited basis by HMO's only (consistent with West Virginia law); see OIC's Informational Letter No. 185, published on March 28, 2013.

Questions regarding this informational letter should be directed to Jeremiah Samples, Director of Health Policy for the OIC, at 304-558-6279 ext. 1131 or jeremiah.samples@wvinsurance.gov.



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[2] As evidenced by the example, this is referring to deviating in amount, duration and scope *within* a specific type of benefit. In addition to this, the federal EHB rule also permits deviation *between* benefit types within an EHB category as long as changes provide actuarially equivalent benefits to the benchmark. For example, a carrier could potentially greatly reduce or eliminate benefit type A within an EHB category if they provided a new benefit type and/or grossly increased an existing benefit type in a manner that was actuarially equivalent to the reduction in the other benefit type. Deviation between benefits types such as this must be justified actuarially.