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January 3, 2012

Approach to Defining Essential Health Benefits

The Department of Health and Human Services (HHS) has issued a Bulletin outlining the intended approach toward developing regulations defining "essential health benefits" or "EHBs." The stated purpose of the Bulletin is to provide information and solicit comments. HHS may modify its approach to defining EHBs in regulations before it finalizes them.

The EHB package will directly apply to plans in the individual and small group markets. There are also implications for plans in the large group market, including self-insured plans. As background, the healthcare reform law requires that beginning in 2014, non-grandfathered health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), must offer a comprehensive package of items and services, known as EHBs. Grandfathered plans, self-insured group health plans, and health insurance coverage offered in the large group market are not required to offer EHBs. However the definition of EHB is an important concern to employer plans and insurers since, beginning in 2017, states may allow large employers to obtain coverage through an Exchange and, thus, the requirement may become applicable to a broader range of plans. Healthcare reform's prohibition on lifetime and annual dollar limits also applies to group health plan coverage for any EHBs, and until final regulations are issued, the regulatory agencies will take into account good faith efforts to comply with a reasonable interpretation of EHBs.

Ten EHB Categories
EHBs must include items and services within at least the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

States need to develop the EHB packages as part of their work to establish the Exchanges in 2014. In addition, states need to know the scope of the coverage because they must pay the cost

of any medical services their laws mandate that go beyond the EHBs. The Bulletin outlines proposed policies that will give states wide latitude to decide what EHBs insurers must offer in policies offered on the Exchanges come 2014. The release of this intended approach should give consumers, states, employers and issuers timely information as they work towards making decisions for 2014. Public input on the Bulletin is encouraged. Comments on EHBs are due by January 31, 2012 and can be sent to: EssentialHealthBenefits@cms.hhs.gov.

Benchmark Plan Approach

Under the announced approach, states would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." States would choose one of the following benchmark health insurance plans for 2014 and 2015:

- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment;
- The largest HMO plan offered in the state's commercial market by enrollment.

The benefits and services included in the benchmark health insurance plan selected by the state would be the EHB package. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. If states choose not to select a benchmark, the default benchmark will be the small group plan with the largest enrollment in the state. To prevent federal dollars going to state benefit mandates, the health reform law requires states to defray the cost of benefits required by state law in excess of EHBs for individuals enrolled in any plan offered through an Exchange. However, as a transition in 2014 and 2015, some of the benchmark options will include health plans in the state's small group market and state employee health benefit plans. These benchmarks are generally regulated by the state and would be subject to state mandates applicable to the small group market. Thus, those mandates would be included in the state EHB package if the state elected one of the three largest small group plans in that state as its benchmark.

Coverage

Not every benchmark plan will include coverage of all 10 EHB categories. If a state selects a benchmark plan that does not cover all 10 categories of care, the state will have the option to examine other insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that must be included in the EHB package. Several options are outlined for determining coverage of habilitative services and pediatric oral and vision care (identified as not commonly covered in some of the benchmark plans). To meet the EHB coverage standard, health plans will be required to offer benefits that are "substantially equal" to the benchmark plan selected by the state and modified as necessary to reflect the 10 EHB categories. Health plans also would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided they continue to offer coverage for all 10 statutory EHB categories and the coverage has the same value.

Updating the Approach

The intent is that benchmarks will be updated in the future, and state mandates outside the definition of EHB may not be included in future years. Updating the benchmark will allow benefits to reflect the most up-to-date medical and market practices.

Lifetime and Annual Dollar Limits

To the extent that an employer plan covers EHBs, they must phase out annual dollar limits on

these benefits by plan years beginning on or after January 1, 2014. The limit requirement poses problems for benefits with annual dollar maximums, such as rehabilitative therapy, durable medical equipment, and certain medical devices. The proposed state-by-state approach to determining EHBs adds to this problem and increases uncertainty for employer plans operating in more than one state. If states adopt different EHB packages, employer plans wishing to maintain annual (or lifetime) dollar limits on certain benefits will have to remove those limits in some states (where the benefits are deemed "essential") but may maintain them in other states.

Cost-Sharing Features of the EHB Package

It is important to note that the healthcare reform law distinguishes between a health plan's covered services, and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. According to an HHS fact sheet, the cost-sharing features of the EHB package will be addressed in separate rules and will determine the actuarial value of the plan., expressed as a "metal level" as specified in the statute: bronze at 60% actuarial value, silver at 70% actuarial value, gold at 80% actuarial value, and platinum at 90% actuarial value.

Should you have questions about this or any aspect of healthcare reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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