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Essential Benefits to be Defined

As the national healthcare reform law continues to evolve, regulators are now focusing on how to define “essential benefits” — the basic medical services that health plans must cover under the law. The definition of essential benefits is the foundation for the coverage to be provided through the state healthcare exchanges in 2014. It is also a key concept in determining an employer's responsibility to provide health coverage and what limits may or may not be imposed on that coverage. The law provides that health plans are prohibited from imposing annual or lifetime limits on the dollar value of "essential benefits.”

Essential Benefits Service Categories. Essential benefits are not defined beyond the following ten general categories listed in the statute:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

Some services that could trigger debate as regulators develop rules further defining these categories include fertility treatments, unlimited length of stay in mental health facility, “lifestyle" medications such as Viagra, chiropractic care, hearing aids, organ transplants, acupuncture, organ transplants and hospice care, unlimited physical therapy, and habilitative services. Until further guidance is issued more fully defining these categories, regulators have indicated that employers must make a good-faith effort to reasonably interpret essential benefits and apply their interpretation consistently.

Lobbying on all categories has been intense. Industry trade groups are emphasizing to policy makers and regulators that costs will rise if insurers have to cover too many specific services, and if they aren't allowed to limit the number of reimbursed services. Insurers and the employer community want to keep the categories as broad as possible so they have flexibility in designing benefits packages. Others in the medical and patient-advocacy communities are pressing for

specifics to be set out and coverage limits to be lifted. Specifics need to be spelled out because if they are not, coverage will likely be denied.

DOL Report on Employer Sponsored Plans. The law requires Health and Human Services (HHS) to define "essential benefits" and further instructs HHS to ensure that the scope of the essential package be equivalent to that of a "typical employer plan", as determined by HHS. The Department of Labor (DOL) conducted a survey of employer-sponsored coverage to determine the benefits typically covered by employers and issued a report to HHS on the results of the survey. The first part of the DOL report summarizes published statistics on the existence of coverage, the extent of coverage and limits on coverage across various kinds of health plans. The second part focuses on specific kinds of care such as emergency room utilization, diabetes care management, kidney dialysis, maternity care, and infertility treatment among others.

Institute of Medicine Study. At the request of HHS, the Institute of Medicine (IOM) is undertaking a study that will make recommendations on the criteria and methods for determining and updating the essential benefits package. The intent is for the entire package to maintain a level of care that is on par with a "typical employer plan." The IOM will try to balance "typical" with "essential" and craft a package that is comprehensive — covering necessary medical services for children, women, seniors and other niche groups across the ten service categories — without being so rich that it's too expensive. The IOM will not define specific service elements of the benefit package, but instead will review how insurers determine covered benefits and then determine how to allow insurers to apply "medical necessity" standards when approving or denying care.

The IOM will provide guidance on the policy principles and criteria for HHS to take into account when examining "qualified health plans" for appropriate balance among categories of care, the health care needs of diverse segments of the population, and nondiscrimination based on age, disability, or expected length of life. Additionally, the IOM will offer advice on criteria and a process for periodically reviewing and updating the essential benefits package. IOM will hold a series of meetings to gather information before issuing its recommendation (scheduled for September release).

Public Comments to be Requested in the Fall. Beginning this fall, HHS will launch an effort, described in an HHS statement, after receiving the IOM's recommendations, to collect public comment and hear directly from all Americans who are interested in sharing their thoughts on this important issue. HHS' final decisions will affect options for tens of millions of people and will lead to a set of coverage standards for significant segments of the private and public markets across the country.

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

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