HHS Proposes to Allow States to Define "Essential Health Benefits"

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The U.S. Department of Health and Human Services (HHS) issued a bulletin on December 16, 2011, outlining and requesting comments on its proposed regulatory approach to allow states to define what is an "essential health benefit."

The Patient Protection and Affordable Care Act (PPACA) has certain provisions that refer to "essential health benefits." For example, group health plans and group health insurance issuers are prohibited from offering group coverage that imposes any lifetime limits on the dollar value of essential health benefits. The PPACA also prohibits (on a phased-in basis) group health plans from imposing annual dollar limits on essential health benefits. Grandfathered plans, health insurance plans offered in the large group market (although fully insured plans remain subject to state insurance law) and self-insured group health plans are not required to cover essential health benefits, but if they do they are subject to the annual and lifetime limit restrictions mentioned above. However, non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover essential health benefits beginning in 2014.

The U.S. Department of Health and Human Services (HHS) issued a bulletin on December 16, 2011, outlining and requesting comments on its proposed regulatory approach to allow states to define what is an "essential health benefit."

Essential health benefits must include at least the following general statutory categories of service:

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
10. Pediatric services, including oral and vision care

The PPACA requires that HHS define essential health benefits to reflect the scope of benefits offered under a typical employer plan. Unfortunately, the statute does not provide a definition of "typical." Therefore, HHS gathered benefit information from a number of sources and generally concluded that these plans cover health care services in virtually all of the 10 statutory categories; however, they differ in the area of cost sharing.

This was not the case with regard to state mandated benefits. Because these laws vary widely in number, scope and topic, generalizing about mandates and their impact on typical employer plans is difficult. HHS found that all states have adopted at least one health insurance mandate, and there are more than 1,600 specific service and provider coverage requirements across the 50 states and the District of Columbia.

In its bulletin, HHS proposes that essential health benefits be defined by states using a benchmark approach that would give each state the flexibility to select a plan that reflects the scope of services offered by a "typical employer plan" within that state. States would choose from one of the following benchmark health insurance plans selected by HHS as reflecting the statutory standards for essential health benefits:

- The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market
- Any of the largest three state employee health benefit plans by enrollment
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment
- The largest insured commercial non-Medicaid Health Maintenance Organization operating in the state

If a state chooses not to select a benchmark, HHS proposes that the default benchmark be the largest plan by enrollment in the largest product in the state's small group market.

Each state would be required to select its benchmark plan in the third quarter two years prior to the coverage year. Thus, for 2014, states would be required to select their benchmark plan in the third quarter of 2012. The benchmark plan options would be determined based on enrollment data from the first quarter two years prior to the coverage year. For example, plan options for 2014 would be determined based on enrollment data for the first quarter of 2012.

If a benchmark plan selected by a state does not include all 10 statutory categories of service listed above, the benchmark plan must be supplemented using the largest plan in the benchmark type that offers the missing category of service. If none of the benchmark options in that type offer the required category of service, the benchmark plan will be supplemented using the FEHBP plan with the largest enrollment. For example, according to HHS, habilitative services and pediatric oral or vision services are not routinely covered by some of the benchmark options it surveyed. If a state selected a benchmark plan using the largest small group insurance plan offered in the state, and the benchmark plan did not provide for habilitative services, the benchmark plan would be supplemented using the habilitative services offered by the largest small group benchmark option with coverage for habilitative services. If no small group benchmark option provides for habilitative services, the benchmark plan will be supplemented with the habilitative services offered under the largest FEHBP plan offering habilitative services. HHS is also considering other options for supplementing habilitative services and pediatric oral or vision services.

Non-grandfathered individual and fully insured small group health plans will be required to offer benefits that are "substantially equal" to the benefits offered under the benchmark plan selected by the state and supplemented, if necessary, to cover all 10 statutory categories of service. The plan's issuer will have the ability to adjust the specific services offered under the plan and/or any quantitative limits, provided the plan covers the baseline set of benefits offered under the benchmark plan and includes all 10 statutory categories of service. HHS is also considering other options for defining the limits on the issuer's flexibility to modify the plan.

The proposed benchmark approach outlined in the bulletin would be applicable for 2014 and 2015. HHS is required by the PPACA to periodically review and update the definition of essential health benefits. HHS proposes to reassess the benchmark approach for 2016 and subsequent years based evaluation and feedback on the proposed process for 2014 and 2015. HHS anticipates that under the benchmark framework, health insurance issuers will update their benefits on an annual basis. HHS also intends to propose a process to evaluate the benchmark

approach. Employers with comments on the proposed regulatory approach outlined in the bulletin should submit their comments to HHS by January 31, 2012.