Essential Health Benefits

Summary:

The Patient Protection and Affordable Care Act (ACA) requires health plans offered in the individual and small group markets, both inside and outside of the Exchanges, to offer a comprehensive package of items and services, known as "essential health benefits."

The essential health benefits (EHB) 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

Essential Health Benefit Bulletin

On December 16, 2011, Consumer Information and Insurance Oversight (CCIIO) released a bulletin outlining the regulatory approach it intends to take on defining the EHB package. The bulletin grants states significant flexibility in determining the benchmark plan to which health insurance EHB packages must be "substantially equal." However, all States must also ensure that the EHB package covers services in the 10 service categories listed in the ACA, reflects "typical employer health benefit plans," and balances comprehensiveness and affordability for those purchasing coverage, among other requirements.

According to the bulletin, states could choose one of the following health insurance plans as a benchmark:

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

Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage.

In 2014 – 2015, if a state chooses a benchmark plan that is required to cover State benefit mandates (such as the small group market benchmark plan), then the state mandated benefits would be included in the State EHB package. In the event that the State chooses to mandate services not

covered under the benchmark plan, they will have to fund such services. The Department of Health and Human Services (HHS) will evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates inclusion in the State EHB package. For years 2014 and 2015, only state benefit mandates that were in effect prior to December 31, 2011, will be considered in determining the composition of the benchmark benefits.

In instances where the benchmark plan does not cover a mandated benefit category, States will have to supplement the benchmark plan to ensure coverage. For instance, if the benchmark plan does not cover prescription drugs, the State may supplement the benchmark with the prescription drug coverage benefit from the Federal Employee Health Benefit Program (FEHBP) plan. Categories that are typically not covered are habilitative services, pediatric oral services, and pediatric vision services.

The bulletin summarizes input from the Institute of Medicine (IOM) and Department of Labor and mentions that the IOM report recommended that the EHB package reflect small employer market plans and provide flexibility to States in constructing EHB packages. The bulletin found that according to reports conducted by the Department of Labor and others, products in the small group market, State employee plans, and the Federal Employees Health Benefit Program Blue Cross Blue Shield Standard Option and Government Employees Health Association plans "do not differ significantly in the range of services they cover," although they do vary in cost-sharing levels.

On January 25, 2012, the Department of Health and Human Services released a list of the three largest small group plans in each State and the top three national Federal Employee Health Benefit Program plans based on enrollment. The intent of the list is to provide models for each State's "benchmark" plan. Although the list includes the names of the plans, it does not identify what benefits are covered by those plans or what benefits the agency would like to see in future plans.

On February 20, 2013, HHS released its final rule that outlines health insurance issuer standards related to the coverage of essential health benefits (EHB) and the determination of actuarial value (AV), while providing significant flexibility to states to shape how EHB are defined. Additionally, the rule proposes a timeline for when issuers offering coverage in a Federally-facilitated Exchange or State Partnership Exchange must become accredited. The rule also proposes an application process for accrediting entities seeking to be recognized to fulfill the accreditation requirements for issuers offering coverage in any Exchange. The final rule largely reflects the approach outlined in the 2011 EHB Bulletin and the proposed rule. ACP has prepared a side-by-side comparison of ACP comments and the final rule on essential health benefits, actuarial value, and accreditation.
On July 5, 2013, HHS released its final rule on Medicaid, CHIP eligibility that includes provisions on Medicaid Alternatives Benefit Plans (ABP) and Essential Health Benefits (EHB). The rule outlines the benchmark plan coverage and eligibility requirements for the new adult Medicaid expansion population. Beginning in 2014, Medicaid benchmark or benchmark equivalent plans (now called Alternative Benefit Plans), that are offered to the new adult Medicaid expansion population, will have to include the ten essential health benefits (EHB). States must choose from four base benchmark plans and modify them to include the ten EHBs to form the Medicaid Alternative Benefit Plans (ABP). Medicaid recipients who qualify under the new adult expansion

must enroll in ABP. Pregnant women, people who are blind or have disabilities, the medically frail, dual eligibles and other identified groups are exempt from mandatory enrollment in ABP and remain entitled to traditional Medicaid benefits.

ACTION: ACP Chapters can contact their State Insurance Commissioner or related entity and urge them to:

- Push state insurance regulators to provide strong oversight of insurers who intend to substitute a benefit within the same essential health benefit category. Oversight is needed to ensure health coverage meets the definition of EHB package, including the requirement that plans reflect the typical employer plan, and that necessary care is included and not substituted in favor of cheaper, less comprehensive benefits and services.
- Support strong oversight of the prohibition on discrimination, which states an insurer's benefit design may not discriminate based on an individual's age, expected length of life, present or predicted disability, quality of life, etc.
- Advocate for states to require that out-of-network cost-sharing expenses count toward the annual limitation on cost-sharing and deductibles.
- Push states to select base-benchmark plans with comprehensive preventive and wellness care and chronic disease management services and supports. The base-benchmark plan should cover comprehensive prescription drug benefits (e.g. greater than the one drug in each USP category/class).
- Request that states support the consideration of clinical and cost-effectiveness in determining the benefit package. ACP policy supports the expansion of value-based health insurance, where use of evidence-based, high-quality services and products is encouraged. This is especially important if plans intend to substitute benefits within categories.

Resources:

- Essential Health Benefits, Actuarial Value, and Accreditation Standards Proposed Rule: Side-by-Side Comparison to ACP Policy
  http://www.acponline.org/advocacy/state_policy/hottopics/side_by_side.pdf
- Comment Letter on the Essential Health Benefits Bulletin
  http://www.acponline.org/acp_policy/letters/cms_essential_health_benefits_2012.pdf
- Essential Health Benefits Bulletin: Side-by-Side Comparison of ACP Policy to the Essential Benefits Bulletin
- HHS Frequently Asked Questions on State Evaluation of Plan Management Activities of Health Plans and Issuers
  http://cciio.cms.gov/resources/files/plan-management-faq-2-20-2013.pdf
- HHS Frequently Asked Questions on the Essential Health Benefits Bulletin
  http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf
- IoM Recommendation for Essential Health Benefits
  http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

- American College of Physicians. Controlling Health Care Costs While Promoting the Best Possible Health Outcomes: 2009 Policy Monograph http://www.acponline.org/acp_policy/policies/controlling_healthcare_costs_2009.pdf