Health and Human Services Bulletin Proposes Standards for ACA Essential Health Benefits (EHBs)

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U.S. Department of Health and Human Services (HHS) issued the *Essential Health Benefits Bulletin (EHBB)*, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf . HHS stopped well short of issuing a detailed rule on what "essential benefits" must be included in the new health exchanges an basically is deferring to the states on what essential health benefits package should look like. Instead, they issued a pre-regulatory bulletin that says states will have the flexibility to choose from four different coverage options already available in their states, an approach that could result in different benefits throughout the country. HHS officials said this bulletin will guide them as they write the regulations in the future. But clearly they are sensitive to the fact that state officials have complained that it's difficult for them to develop their exchanges without a key element: what benefits they have to offer.

The bulletin provides helpful background statutory information and describes HHS's intended approach toward developing regulations defining "essential health benefits" (EHB). As required under the Patient Protection and Affordable Care Act (ACA), the essential benefits package will establish the minimum that must be covered by certain health plans, including those participating in state-based health insurance exchanges. 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 the EHB beginning in 2014.

In ACA, 1 Section 1302 (b)(1) provides that EHB include items and services within the following 10 benefit 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.

If a state selects a plan that does not cover all of those categories, it must look at other plans to fill the gaps. States could modify coverage within a benefit category if it doesn't reduce the value of the coverage. Self-insured group health plans, health insurance coverage offered in the large group market and grandfathered health plans are not required to cover the essential health benefits.

Public input is welcome on this intended approach/bulletin.
Please send comments on the bulletin by January 31, 2012 to:
EssentialHealthBenefits@cms.hhs.gov

HHS is touting that this approach recognizes that issuers make a holistic decision in constructing a package of benefits that balance consumer needs for comprehensiveness and affordability. The approach will be used for 2014 and 2015, after which HHS will evaluate the results and develop a process for updating benefits and taking into account innovations in care.

This approach is intended to give states the flexibility to choose a plan that is equal in scope to services covered in a typical employer plan in their state states and would develop their benefit packages based on coverage in one of the three largest small-group plans in the state; the state employee health plans, or from the federal employee

health plan options. They also could choose the largest HMO plan offered in the state's commercial market. States not choosing a benchmark would automatically be assigned an essential benefits package equal to the small-group plan with the largest enrollment in the state. HHS officials told reporters the method is similar to that used to define benefits in the State Children's Health Insurance Program and for some Medicaid recipients.

This intended approach addresses:

- four "Benchmark Plan" types for states to select as the standard for qualified health plans offered inside an exchange as well as small group markets;
- standards for defraying the cost of state-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market;
- the Benchmark Plan approach and the ten identified benefit categories, including habilitative services, pediatric oral and vision coverage and mental health and substance use disorder services and parity;
- benefit design flexibility; and
- periodic review of EHB

Implications for Large Employers

While the essential health benefits package will directly apply to plans in the individual and small group markets, there are implications for plans in the large group market, including self-insured plans. ACA's prohibition on lifetime and annual dollar limits applies to group health plan coverage for any "essential health benefits," as determined in HHS guidance. As we have previously reported, interim final regulations (IFR) issued in June 2010 implementing these limits stated that the regulatory agencies will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for plan years that begin before final regulations are issued defining the term.

Implications for Large Self-Insured Employers

As provided for in the ACA statute, EHB standards apply to the coverage provided by qualified health plans participating in the state health exchanges which will service individuals and small businesses starting in 2014.

However, there are a couple of scenarios in which EHBs will impact large-self insured employers as well.

1. It is important to make the distinction between essential health benefits, which as stated before applies to the exchanges, and the "essential minimum coverage" requirement, which is related to the employer and individual mandate in the "pay or play" aspect of the reform bill.
    - Under pay or play, to avoid a tax penalty, individuals are responsible to show they have a plan meets the EHB requirements, or that they are in an employer plan that meets the "essential minimum coverage" requirement .
    - The "essential minimum coverage" requirement is composed of two criteria: 1) 9.5% affordability - Affordable = employee contribution less than 9.5% of income; 2) 60% actuarial value test. Effective 2014, an employer with 50+ employees must provide "minimum essential benefits" (**Play)** and must provide coverage to all FTEs defined as 30+ hours per week.
    - The employer penalty for non-compliance will be equal to $2,000 per FTE who enrolls in an exchange (**Pay)**. The problem is that like the essential health benefit standard, HHS hasn't issued rules on the "essential minimum coverage" requirement. In particular, there needs to be more direction from HHS on the 60% actuarial value test relative to what is the denominator (i.e. the standard for comparison). The current thought among employer groups is that the essential health benefit will be used by HHS as the standard or denominator for the 60% actuarial value test, and perhaps for the "essential minimum coverage" standards in general.

2. In terms of further linkage of EHB and self-insured employers, ACA's prohibition on lifetime and annual dollar limits applies to group health plan coverage for any "essential health benefits," as determined in HHS guidance. As we have previously reported, interim final regulations (IFR) issued in June 2010

implementing these limits stated that the regulatory agencies will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for plan years that begin before final regulations are issued defining the term. Basically, employers will need to know what are benefits are covered as EHBs so that they can determine what benefits can be capped or limited (i.e. chiropractic procedures and infertility treatment).

Key Concerns with Interim Bulletin

- There is no national standard or uniformity for a federal floor to the benefit design leading to a state patchwork of care.
- HHS failed to provide any guidance on copays, deductibles and premiums. HHS said in the bulletin that cost sharing, which entails the most variation at the state level, would be addressed in future announcements and that those rules will determine the actuarial value of the plan.
- States could discriminate by selecting plans that do not provide comprehensiveness or short-change one of the 10 benefit areas or health plans appear to be offering benefits that are skewed to avoid providing coverage for people with major illnesses or disabilities to keep costs down. Coverage categories of particular interest, such as rehabilitative, habilitative or mental health and substance abuse services, that often are not provided in some employer plans.
- There is the ongoing concern, particularly by Republicans in Congress, that mandated benefits should be reconsidered entirely because the benefit mandates in the health law can only lead to higher costs for families and small businesses. They are concerned that ACA coverage requirements are unworkable at a time of economic uncertainty and high unemployment,

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Key Information Resources

Public input on this proposal is encouraged. Comments are due by Jan 31, 2012 and can be sent to: EssentialHealthBenefits@cms.hhs.gov.

For the essential health benefits bulletin, visit:
http://cciio.cms.gov/resources/regulations/index.html#hie

For a fact sheet on the essential health benefits bulletin, visit:
http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

For a summary of individual market coverage as it relates to essential health benefits, visit:
http://aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.shtml

For information comparing benefits in small group products and state and Federal employee plans, visit:
http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml

(Sources: Congressional Quarterly, HealthBeat, December 16, 2011; American Benefits Council, BenefitsByte, December 16, 2011)