Health Care Reform
LEGISLATIVE BRIEF

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HHS Proposes Approach for Defining Essential Health Benefits

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered plans in the individual and small group markets to offer a comprehensive package of items and services, known as **essential health benefits**. This requirement applies to plans offered inside and outside of the state insurance exchanges (Exchanges), which are scheduled to become effective in 2014.

(**Notably, self-insured group health plans, health insurance coverage offered in the large group market and grandfathered plans are not required to cover essential health benefits. It is presently uncertain how or if the proposed process for defining essential health benefits and the eventual application of that process in the individual and small group markets will impact self-insured plans down the road.)**

PPACA identified in broad terms 10 benefit categories that must be included as essential health benefits. PPACA also directed the Department of Health and Human Services (HHS) to more specifically define the items and services that comprise essential health benefits.

On Dec. 16, 2011, HHS released an informational bulletin (Bulletin) outlining its proposed approach for defining essential health benefits. It was expected that HHS's guidance would detail the items and services that must be covered as essential health benefits. Instead, HHS's approach defers to the individual states by giving them flexibility to select their own benchmarks for defining essential health benefits.

This Chelko Consulting Group Legislative Brief provides an overview of HHS's proposed approach for defining essential health benefits.

ESSENTIAL HEALTH BENEFITS

PPACA provides that essential health benefits must include items and services within at least the following 10 categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder benefits, including behavioral health treatment;
- 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.

As noted above, PPACA directs HHS to further define the scope of essential health benefits.

PROPOSED APPROACH

Defining Essential Health Benefits
In the Bulletin, HHS outlines a benchmark approach for defining essential health benefits. Under this approach, each state would select a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state. States would choose from one of the following benchmark plans:

- 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; or
- The **largest HMO plan** offered in the state's commercial market by enrollment.

If a state does not select a benchmark plan, the default benchmark would be the small group plan with the largest enrollment in the state.

The items and services included in the selected benchmark insurance plan would be the essential health benefits package.

However, if a state selects a benchmark plan that does not cover the 10 categories of care specified under PPACA, the state would have the option to examine other benchmark insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that must be included in the essential health benefits package.

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Making Benefit Design Decisions
HHS would require health plans to offer benefits that are "substantially equal" to the benchmark plan selected by the state, and modified if necessary to include PPACA's 10 categories of coverage. According to HHS, health plans would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits, so long as they offer coverage for all 10 categories and the coverage has the same value.

Coverage of State Benefit Mandates
States typically have a number of benefit mandates, which require health insurance issuers to provide coverage for certain items or services. To prevent federal funding of state benefit mandates, PPACA requires states to defray the costs of state-mandated benefits in excess of essential health benefits for individuals enrolled in any plan offered through an Exchange.

However, as a transition for 2014 and 2015, if a state chooses a benchmark subject to state mandates (for example, one of the three largest small group plans in the state), the benchmark would include those mandates in the state's essential health benefits package. Alternatively, if a state selected a benchmark that did not include some or all of the state's benefit mandates (for example, one of the three largest federal employee health plan options), the state would be required to cover the cost of those mandates outside of the state's essential health benefits package.

HHS intends to evaluate the benchmark approach for the year 2016 and will develop an approach that may exclude some state benefit mandates from inclusion in the state's essential health benefits package.

ADDITIONAL GUIDANCE

HHS issued the Bulletin to give consumers, states, employers and issuers up-to-date information as they work on establishing the Exchanges and making benefit decisions for 2014. The benchmark method outlined by HHS is not final, but it is a good indicator of the approach HHS intends to take to define essential health benefits. HHS encourages comments on the Bulletin, which are due by Jan. 31, 2012.

HHS intends to issue regulations in the future that will more formally outline its approach for defining essential health benefits. HHS also intends to issue guidance for other aspects of the essential health benefits package, such as cost-sharing (deductibles, copayments and coinsurance) rules for determining the plan's actuarial value.

The Chelko Consulting Group will continue to monitor the process of defining essential health benefits and all other health care reform developments and will provide updated information as it becomes available.

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