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Summary of Essential Health Benefits Bulletin

The Patient Protection and Affordable Care Act ("ACA") requires health insurance issuers in the individual and small group market to cover the "essential health benefits." In an effort to begin developing the regulatory regime for implementing these statutory provisions, on December 16, 2011, the Center for Consumer Information and Insurance Oversight ("CCIIO") at the Department of Health and Human Resources ("HHS") issued Essential Health Benefits Bulletin ("the Bulletin"). The Bulletin is not binding guidance, but does outline the process CCIIO intends to follow as it defines the "essential health benefits." Shortly after the release of the Bulletin, HHS released additional "complementary" guidance that further illustrates the Bulletin's proposed process.

While the Bulletin is of primary interest to health insurance issuers in the individual and small group market, self-funded group health plans may also be affected because group health plans are prohibited from lifetime caps on essential health benefits and after 2014, will also be prohibited from imposing annual dollar limits on essential health benefits.

This brief summary of the Bulletin highlights the major issues that may have the most potential impact on issuers and employers.

I. Background

Insured non-grandfathered plans in the individual and small group market, as well as plans offered through an Exchange, will be required to offer "essential health benefits" beginning in 2014. The essential health benefits must include items and services in the following general categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

ACA § 1302(a). As noted above, group health plans (including self-funded plans) are currently prohibited from placing lifetime dollar limits on essential health benefits. Plans may currently impose "restricted" annual dollar limits on essential health benefits; in 2014, annual dollar limits on essential health benefits are prohibited.

II. Benchmark Proposal

CCIIO proposes to adopt a "benchmark" standard for the essential health benefits for 2014 and 2015. Rather than defining what benefits and services must be provided as "essential," under the proposal, states would choose a "reference" plan. States must choose the benchmark plan from four benchmark plan types:

- (1) the largest plan by enrollment in any of the three largest small group insurance produces in the state;
- (2) any of the largest three state employee benefit plans;
- (3) any of the largest three national Federal Employee Health Benefits Program ("FEHBP") plans; or
- (4) the largest commercial HMO in the state.

If a state does not choose, the benchmark would be the largest plan by enrollment in the small group market.

Benchmark plans must include services in all 10 statutorily-required categories. While CCIIO believes that products in the four permissible plan types "generally cover health care services in virtually all" of the 10 required categories, the Bulletin would require that a state "supplement" a benchmark plan to the extent that the benchmark plan fails to cover a category of benefits. The Bulletin does not provide guidance as to what it means for a benchmark to be "missing a category" of benefits, but it does state that the "most commonly non-covered categories of benefits among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services."

The Bulletin proposes that a state select the 2014 benchmark plan during the third quarter of 2012. In separate guidance, HHS released an "illustrative" list of the largest three small group products in each state, based on data collected by healthcare.gov, the webportal created by the ACA. HHS also released a list of the largest three nationally available FEHBP plans.

III. State Benefit Mandates and State Transitional Relief

The ACA requires states to pay (to the individual or to the health plan on behalf of the individual) for the additional costs of any state-mandated benefits above the essential health benefits. ACA § 1311(d)(3)(B). However, the four benchmark plan types, with the possible exception of the FEHBP option, likely already include any state mandated benefits. Under the Bulletin's proposed approach, states would likely not be subject to any additional costs. However, if a state chose a benchmark that was not subject to some or all of the state benefit mandates, the state would be required to cover the cost of any state-mandated additional benefits. As a result, states have an incentive to choose a plan that already includes coverage of the essential health benefits. HHS intends to develop, by 2016, a process through which some state-mandated benefits might be excluded from the state EHB package.

IV. Benefit Flexibility

The Bulletin indicates a desire by HHS to provide some flexibility in benefit design. Specifically, the Bulletin proposes that a health plan would only be required to offer benefits that are "substantially equal" to the state benchmark plan. Health plans would be able to "adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories."

CCIIO intends that the "substantially equal" equivalency standard will mirror that applied to CHIP plans.

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The application of the CHIP actuarial standard in the context of the ACA, where plans must already conform to actuarial levels (i.e., bronze, silver, gold, and platinum), will likely require more explanation from CCIIO to ensure that health plans are able to conform both individual benefits, under the EHB construct, and overall actuarial value of the plan. In general, the Bulletin does not provide a great deal of clarity as to how much flexibility plans will have in designing benefits that are substantially equal to the benchmark plan.

V. Large Group and Self-Funded Plans

While the Bulletin explicitly addresses EHB for purposes of the individual and small group market, the definition of the essential health benefits is critical to self-funded and large group plans. Under the ACA, group health plans and health insurance issuers are prohibited from placing annual or lifetime limits on benefits that are "essential." Because of the potential inclusion (for 2014 and 2015) of state-mandated benefits in the benchmark EHB plan for each state, the proposal outlined by CCIIO may become difficult for self-funded plans operating in multiple states to administer, as every state may have different essential health benefits.

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