**Essential Health Benefits Bulletin**
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Summary
December 16, 2011

The Department of Health and Human Services (HHS) released on December 16, 2011 an Essential Health Benefits Bulletin to provide information and solicit comments on the approach that the Department is planning to propose to define essential health benefits (EHB) under the Affordable Care Act.

The approach would allow each State to determine a "reference plan" based on one of several options for defining employer-sponsored coverage in the State, supplemented as needed to ensure that the reference plan covers each of the 10 categories of benefits in the statute.

Comments on the proposal that is set out in the bulletin are due by January 31, 2012, and are to be submitted to EssentialHealthBenefits@cms.hhs.gov.

**Introduction and background**

HHS sets out the statutory framework provided by section 1302 of the ACA.

- The EHB applies, starting in 2014, to non-grandfathered plans in the individual and small group markets both inside and outside the Exchanges; Medicaid benchmark and benchmark-equivalent plans; and Basic Health Programs.
- The scope of the EHB must equal the typical employer plan.
- The EHB must include items and services in 10 benefit 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 and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.
- Benefits must not be designed in ways that discriminate based on age, disability, or expected length of life and must consider the health care needs of diverse segments of the population.

HHS describes the process to date of soliciting information and public input. That includes a report from the Department of Labor on employer plans, and a report and recommendations from a study panel at the Institute of Medicine (IOM), commissioned by HHS, entitled "Essential Health Benefits: Balancing Coverage and Costs." Following the release of the IOM report, HHS held a series of listening sessions around the country to hear from a range of stakeholders.

**Summary of research on employer sponsored plan benefits and state benefit mandates**

HHS reviews information on large employer plans including the Federal Employee Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option, small employer products, and plans offered to public employees.

In general, HHS reports that the scope of benefits in the different markets do not differ significantly in the range of services covered: they differ mainly in the cost sharing provisions. As IOM also reported, the plans generally cover items and services in virtually all of the 10 categories of coverage identified by the statute.

There is, however, some variation in coverage of a few specific services, although it is not systematic variation among the markets. For example:

- Some plans, such as the FEHBP BCBS Standard Option, cover preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications, while small employer plans do not consistently provide such benefits.
- In other cases, small group plans cover services not included in the FEHBP plans, especially in States that mandate coverage of benefits such as in-vitro fertilization (IVF) and applied behavior analysis (ABA) for children with autism.
- HHS notes in particular that there is variation in coverage for a subset of the 10 categories of coverage: mental health and substance use disorder services, pediatric oral and vision services, and habilitative services. HHS reviews each of these categories of coverage in detail.

HHS reviews State benefit mandates, and notes that almost all State mandated benefits are typically covered in employer benefit packages even in States without such mandates. This includes items such as immunizations and emergency services. The FEHBP BCBS Standard Option, which is not subject to State mandates, still covers about 95 percent of the benefit and provider categories that are the subject of State mandates. The primary exceptions are IVF and ABA therapy for autism, mandates that typically include limits of some sort – annual dollar, lifetime, frequency and/or age limits.

**Intended regulatory approach**

HHS sets out its goals, which reference the statutory standards as well as the need to balance comprehensiveness, affordability, and State flexibility while taking into account public input. HHS intends to propose that the EHB be defined by a benchmark plan selected by each State, which would serve as a reference plan reflecting the scope of benefits and any limits offered.

<u>Four benchmark plan types</u>

HHS sets out four benchmark options for the States to select for 2014 and 2015:

- One of the three largest small group insurance products in the State;
- One of the three largest State employee health plans in the State;

- One of the three largest FEHBP plan options;
- The largest HMO plan offered in the State's commercial market.

If a State does not make a selection, the default option would the largest product in the small group insurance market in the State.

HHS proposes to use enrollment data from the first quarter of 2012 to determine, in the third quarter of 2012, the benchmark plan options for purposes of defining the EHB for the State for the coverage year 2014; that rolling schedule would be maintained for future years.

Defraying the cost of additional benefits

HHS notes the ACA requirement that States defray the costs of State-mandated benefits in excess of the EHB to the extent that these mandates increase the cost to the federal government of premium tax credits and cost sharing subsidies provided to individuals for coverage in the State's Exchange.

HHS notes that if, for 2014 and 2015, the State selects a benchmark subject to the State mandates (such as the small group benchmark) then the benchmark would already include such benefits so the State would not be responsible for picking up any extra costs. If the State opts instead for a benchmark such as the FEHBP option, and it does not include all of that State's mandates, then the State would be required to cover the cost of the extra benefits required by the State mandates.

Benchmark plan and the 10 benefit categories

HHS reviews the issue arising if the benchmark selected by a State does not include each of the 10 categories identified in the statute. In general, HHS would require that the State supplement the benefits in the benchmark plan to include the missing categories:

- It would first turn to the largest plan in the benchmark type selected by the State (the four options above – such as small group) that does offer benefits in the missing category – and that would become the benchmark benefit (just for the missing category of benefits).
- If none of the plans offer benefits in the missing category, the largest FEHBP plan offering the missing category of benefit would become the benchmark for the missing category of benefits.

*Habilitation services, and pediatric oral and vision care*

HHS notes particular uncertainty about the definition of coverage of habilitation services and oral and vision care.

*Habilitation:* For habilitation services, HHS is considering two options for supplementing benchmarks that do not include the categories:

- Offer habilitative services at parity with rehabilitative services;

- As a transitional approach, plans would decide which habilitative services to offer and report on that coverage to HHS, with HHS defining coverage in the future.

*Pediatric oral care:* For pediatric oral care, HHS is considering two options for supplementing benchmarks:

- The FEHB Dental and Vision Insurance Program dental plan with the largest national enrollment; or
- The State's CHIP program.

HHS notes that it does not intend to propose to include non-medically necessary orthodontic benefits.

*Pediatric vision care:* For pediatric vision care, HHS intends to propose that the benchmark be supplemented by the FEHB Dental and Vision Program vision plan with the largest enrollment (noting that CHIP does not cover vision services).

*Mental health and substance use disorder services and parity:*

HHS intends to propose that parity requirements apply in the context of the EHB.

*Benefit design flexibility*

HHS intends to require that a health plan offer benefits that are "substantially equal" to the benefits of the benchmark plan selected by the State and modified to reflect the 10 coverage categories. This is the same standard that applies to CHIP. HHS notes that this includes flexibility to adjust specific services covered and any quantitative limits.

HHS notes that it is considering:

- Allowing substitutions that may occur only within each of the 10 specified benefit categories;
- Allowing substitution across benefit categories.

HHS seeks input on whether substitution across categories should be subject to a higher level of scrutiny. HHS intends to require that substitution be actuarially equivalent.

For pharmacy benefits, HHS intends to propose the flexibility permitted under Medicare Part D: plans must cover the categories and classes of drugs in the benchmark, but my choose specific drugs within those categories and classes.

*Updating essential health benefits*

HHS will assess access, and invites comments on approaches it should take. HHS notes that under the benchmark standards, health insurance issuers will have the opportunity to update their benefits on an annual basis. It will propose a process to evaluate the benchmark approach.