EXPERT UPDATE

Standards Related to Essential Health Benefits

HENDERSON BROTHERS

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The Affordable Care Act directs health insurance issuers that offer non-grandfathered health insurance coverage in the individual and small group market to make certain health plans offered include the Essential Health Benefits package starting January 1, 2014. The proposed regulations indicate that this Essential Health Benefit requirement, along with certain cost-sharing limitations, shall apply to individual and small group market plans both inside and outside the Exchange. The benefit requirements and cost-sharing limitations shall not apply to self-insured health plans and health insurance coverage offered in the large group market.

State Required Benefits

The Act permits a state to require Qualified Health Plans offered in the Exchange to provide benefits beyond the required Essential Health Benefits package, but stipulates that the state must then make payments to the individual enrollee or the health plan issuer to defray the cost of these additional benefits. HHS is proposing that state-required (mandated) benefits enacted on or before December 31, 2011, may be considered Essential Health Benefits (EHB), therefore eliminating the requirement for the state to pay for these state-required benefits. HHS is also proposing that state-required benefits that are not included in the benchmark plans selected would apply to Qualified Health Plan markets in the same way they apply in the current market.

This proposed policy regarding state-required benefits is intended to apply for at least two years, beginning in 2014.

HHS interprets state-required benefits to be specific to the care, treatment and services that a state requires health insurers to offer to its enrollees. State rules related to provider types, cost-sharing, or reimbursement methods would not fall under the definition of state-required benefits. Although health plans must comply with these provider-type, cost-sharing and reimbursement method mandates, there will be no federal obligation for states to defray the costs associated with these requirements. Since the Exchange is responsible for certifying Qualified Health Plans, HHS proposes that the Exchange identify which additional state-required benefits, if any, are in excess of the required Essential Health Benefits package.

Benchmark Plans

HHS proposes that the "base-benchmark plan" which means the plan that is selected by a state, be the benchmark program. The benchmark standard that is used to determine Essential Health Benefits shall be called the "EHB-benchmark plan" and will apply to non-grandfathered health coverage offered in the individual and small group markets. This EHB-benchmark plan will apply for at least the 2014 and 2015 benefit years and will serve as a reference plan, reflecting the scope of services offered and plan limits offered by a typical employer plan in the state. HHS proposes that "EHB package" means the scope of covered benefits and associated limits of a health plan offered. This EHB package must provide at least the ten statutory categories of benefits and cost-sharing limits as described in the Act. The EHB requirement applies to states and U.S. territories. HHS also proposes that multi-state plans must meet benchmark standards set by the U.S. Office of Personnel Management (OPM). Guidance and regulations are expected for OPM's Multi-State Plan Program (MSPP).

Essential Health Benefits - Ten Benefit Categories

HHS proposes that that the EHB-benchmark plan must provide coverage of at least the following categories of benefits described in section 1302(b)(1) of the Affordable Care Act: (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.

HHS interprets "pediatric services" to mean services for individuals under the age of 19 years. While HHS recommends that coverage of pediatric services be provided up to age 19, the proposed regulations indicate that states have the flexibility to extend coverage beyond the 19 year age limit. States are also provided with two options for supplementing base benchmark plans that do not include benefits for pediatric oral care coverage. States can use the FEDVIP dental plan with the largest enrollment as its benchmark or the state's CHIP program, if applicable. The proposed regulations provide similar solutions when the base benchmark plan does not include pediatric vision service as well. The proposed regulations also provide direction on what coverage to provide when other services, like habilitative and maternity services, are not included in the EHB-benchmark plan.

As a response to comments, HHS has also provided direction in the proposed regulations regarding prescription drug benefits. The proposed regulations indicate that a Qualified Health Plan (QHP) would need to cover at least the greater of 1) one drug in every category and class; or 2) the same number of drugs in each category and class as the EHB-benchmark plan. It is also proposed that each QHP must report its drug list to the Exchange. A health plan operating outside of the Exchange must report its drug list to the state, and a multi-state plan must report its drug list to the OPM. It is also proposed that plans offering Essential Health Benefits have procedures in place to ensure that enrollees have access to clinically appropriate drugs that are prescribed by a provider, but not included on the plan's drug list, consistent with how many plans operate today. Comments have been solicited for this proposed requirement.

Limits on Cost Sharing

Cost sharing, as defined in the Act, is any expenditure required by an enrollee with respect to essential health benefits. The term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing and spending for non-covered services. Once the limitation on cost sharing for an individual enrolled in an Qualified Health Plan is reached for the year, the enrollee is not responsible for additional cost sharing in the EHB for the remainder of the year. Under the proposed regulations, cost sharing requirements for benefits from a provider outside of a plan's network do not count towards the annual limitation on cost sharing.

The Act identifies that the annual limitation on cost sharing is tied to the enrollee out-of-pocket limit for high deductible health plans pursuant to Internal Revenue Code. For illustrative purposes only, the annual cost sharing limits would be $6,250 for self-only coverage and $12,500 for non-self only coverage beginning in 2014. It is

proposed that the annual limitation on cost sharing be increased by the premium adjustment percentage for years after 2014. Consistent with the Essential Benefit requirements, this limitation is imposed on non-grandfathered coverage in the individual and small group market, and will not impact the level of benefits offered by self-insured plans and coverage offered in the large group market. Additional comments have been requested.

Additional information regarding the information provided in this compliance update can be found in the following proposed rule:

http://www.ofr.gov/OFRUpload/OFRData/2012-28362_PI.pdf

We expect additional guidance to be released. Stay tuned for more details.

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