

Essential Health Benefits

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Why are Essential Health Benefits Important?

- Insured plans in individual & small group market & plans offered through Exchange must offer “essential health benefits” in 2014.
- Requirement does not apply to self-funded plans or insured plans in large group market.

Why are Essential Health Benefits Important?

- Plans may not impose annual or lifetime dollar limits on “essential health benefits.”
- Applies to insured & self-funded plans (all markets).
- Applies to plan years on or after 9/23/10 (1/1/11 for calendar year plans).
- Restricted annual limits allowed until 2014
 - \$750,000 in 2011
 - \$1.25 million in 2012
 - \$2 million in 2013

What are Essential Health Benefits?

PPACA statute lists following categories:

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

What are Essential Health Benefits?

- Statute says Secretary shall define “essential health benefits,” which shall include at least above categories.
- Secretary shall ensure scope of EHB is equal to scope of benefits provided under “typical” employer plan.
- DOL required to conduct survey of employer-sponsored coverage.
- Secretary to update EHB periodically to address gaps in coverage or access.

What are Essential Health Benefits? Informal Guidance

- No formal guidance other than list of 10 categories.
- FAQ says that, for purposes of enforcement, agencies “will take into account good faith efforts to comply with a reasonable interpretation of the term ‘essential health benefits.’”
 - Part IV, Q&A-3 (www.dol.gov/ebsa)

New Guidance: HHS Bulletin (12/16/11)

- Stated purpose is to provide information and solicit comments on regulatory approach HHS plans to propose to define EHBs.
- States that individual/small group market insurers and Exchange must offer EHBs as of 2014.
- Confirms that self-funded and large group market plans are not required to offer EHBs.
- Does not address whether/how applies to EHBs for purposes of annual/lifetime limits.
- Comments were due 1/31/12.

New Guidance: HHS Bulletin (12/16/11)

- “We intend to propose that EHB be defined by a benchmark plan selected by each State.”
- States would identify “benchmark” plan from:
 - The largest plan by enrollment in any of 3 largest small group insurance products in State;
 - Any of largest 3 State employee benefit plans by enrollment;
 - Any of largest 3 national FEHBP plan options by enrollment; or
 - Largest commercial HMO in State.

New Guidance: HHS Bulletin (12/16/11)

- If State does not choose, default is largest plan by enrollment in small group market in State.
- Accompanying guidance lists applicable plans by State.
- Benchmark plans must include services in 10 EHB categories or must “supplement” category with category from another benchmark plan (or FEHBP if no benchmark available).

New Guidance: HHS Bulletin (12/16/11)

- “To meet EHB coverage standard, HHS intends to require that a health plan offer benefits that are ‘substantially equal’ to benefits of the benchmark plan selected by the State and modify as necessary to reflect the 10 coverage categories.”
- Proposes flexibility to adjust benefits, including specific services covered and quantitative limits.
 - Must still provide coverage in 10 categories, but may make some substitutions within or perhaps across categories.
 - Intend to require that substitution be “actuarially equivalent.”

Questions for Large Group Market & Self-Funded Plans

- Does this bulletin apply to annual & lifetime limits?
 - Bulletin is silent on annual & lifetime limits (and is not binding), so arguably “reasonable interpretation” guidance still applicable.
 - Otherwise, plans may be subject to 50 different versions of EHB.

Questions for Large Group Market & Self-Funded Plans

- Will Secretary use different definition of EHBs for these two different requirements?
 - Clearly an issue if Secretary lets States define EHBs for large group and self-funded plans because multiple standards.
 - Even if a single EHB list is adopted for purposes of annual & lifetime limits, will plans feel pressure to go with State benchmarks?
 - Plans at least may need to clearly communicate coverage if other plans in State uniformly offering some minimum level of benefits.
- Will Secretary issue further guidance or regulation?

Practical Observations

- Most self-funded plans still looking to “reasonable interpretation” guidance.
- Many plans replaced all annual and lifetime dollar limits with visit or treatment limits for 2011 plan year.
- Some considering adding back at least some dollar limits.
- Benefits that seem to be most in question (anecdotally): fertility, chiropractic, hearing aids, vision / lasik, durable medical equipment, acupuncture, home health care (with plans taking varying views).

Questions?



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