

# Essential Health Benefits

The Affordable Care Act of 2010 (ACA) requires insurers to provide coverage for an Essential Health Benefits (EHB) package in 10 benefit categories, effective the first plan year on or after January 1, 2014. These requirements apply to all fully insured health plans offered in the Individual and Small Group insured markets (both inside and outside of Exchanges). EHB requirements do not apply to ASO plans (regardless of group size), fully insured Large Group plans or any grandfathered plans.

The Essential Health Benefits package encompasses these 10 benefit categories:

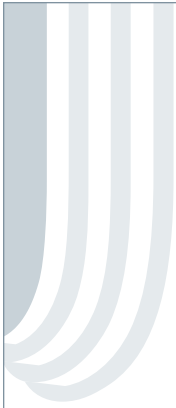
- ▶ Ambulatory patient services
- ▶ Emergency services
- ▶ Hospitalization
- ▶ Laboratory services
- ▶ Maternity and newborn care
- ▶ Mental health and substance abuse services, including behavioral health treatment
- ▶ Prescription drugs
- ▶ Rehabilitative and habilitate services and devices
- ▶ Preventive and wellness services and chronic disease management
- ▶ Pediatric services, including oral and vision care

## What's In Scope and Out of Scope

The requirement to add Essential Health Benefits applies to all non-grandfathered Individual plans and non-grandfathered, fully insured Small Group plans inside and outside of Exchanges.

### **The following plans are not required to add Essential Health Benefits:**

- ▶ Large Group fully insured
- ▶ Self-funded (ASO) plans
- ▶ Grandfathered plans



*All plans (even those that are not required to offer EHBs) that include any Essential Health Benefit must remove any annual or lifetime dollar limits.*

Of the 10 required coverage categories, pediatric dental and vision have not been typically covered in the Small Group market. In addition, habilitative services (which have not been uniformly defined) are generally not covered explicitly, but in most instances are typically covered at parity with rehabilitative benefits.

## **Out-of-Pocket Maximum (OOPM)**

The expanded benefits package that will be incorporated in new plan designs for all funding types and employer sizes has new accumulation rules for the out-of-pocket maximum, with the OOPM ceiling set at the HSA level. The OOPM ceiling will be \$6,350 (for self-only coverage) and \$12,700 (for other than self-only coverage) in 2014, with future increases indexed for inflation. All cost-sharing for Essential Health Benefits must accumulate to the OOPM. For plans that have in- and out-of-network benefits, only the in-network benefits are subject to the OOPM ceiling.

## **Small Group Deductible Limits**

The deductible caps for Small Group plans in 2014 have been set at \$2,000 for single coverage and \$4,000 for family coverage. The cap does not apply to ASO plans (regardless of group size), Large Group fully insured plans or to plans in the Individual market. As with the OOPM, the deductible caps will be indexed for inflation. For plans that have in- and out-of-network benefits, only the in-network benefits are subject to the deductible caps.

The pricing impact of the EHB requirements is uncertain as states are still in the process of selecting benchmark plans that will establish the scope of Essential Health Benefits, and until more is learned about the four “metallic” tiers of coverage that will be required in and out of Exchanges.

## **New Benefit and Coverage Rules**

Beginning in 2014, there will be four tiers of coverage for EHB packages: Bronze, Silver, Gold and Platinum. In addition, insurers will be allowed to offer Individual catastrophic coverage to individuals under age 30.

These metallic packages will be offered in and out of Exchanges, with a requirement to meet the actuarial value of at least one of the four metallic levels. In addition, plans offered in an Exchange must include at least a Silver-level plan and a Gold-level plan.

Pre-existing condition exclusions must be removed for all members, not just those under age 19, and all fully insured plans must have guaranteed issue and renewability.

The federal government issued guidance at the end of 2012 regarding the Employer Mandate. The Employer Mandate requires employers with more than 50 employees to provide full-time employees and their dependents with minimum essential coverage in order to avoid a shared responsibility payment. The proposed rule has a comment period that will extend into the second quarter of 2013.

The minimum essential coverage must be affordable so that the employee contribution does not exceed 9.5 percent of employee income and must provide minimum value in which the employer pays more than 60 percent of covered plan expenses. Further guidance is anticipated on how minimum essential coverage will be calculated.

## **Most Common Non-Covered Benefits**

The following Essential Health Benefit categories have not generally been covered under most typical employer plans:

- ▶ Habilitative services
- ▶ Pediatric oral services
- ▶ Pediatric vision services

Plans will now have to cover these benefits. If a state benchmark plan does not cover one or more of these three essential benefit categories, then the Department of Health and Human Services (HHS) proposes that states supplement their benchmark plan as follows:

- ▶ If the benchmark plan does not include coverage for habilitative services, then the plan must include coverage for habilitative services in one of the following ways:
  - (1) Cover habilitative services at parity with rehabilitative services [physical therapy (PT), occupational therapy (OT) and speech therapy (ST)], or
  - (2) Decide which habilitative services to cover and report that decision to HHS, which will evaluate and further define habilitative services in the future
- ▶ If the benchmark plan does not include coverage for pediatric dental and/or vision, then the plan must be supplemented by the addition of pediatric dental and vision services as provided under:
  - (1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan and FEDVIP vision plan with the largest national enrollment, or
  - (2) The state's Children's Health Insurance Program (CHIP)

## State Benchmark Decisions

In 2014 and 2015, states may define the EHB package by selecting a benchmark plan reflecting the scope of services offered by a “typical employer plan” from one of the following benchmark health insurance plan options:

- ▶ The largest plan by enrollment in any of the state’s three largest Small Group insurance products
- ▶ Any one of the three largest state employee health plans by enrollment
- ▶ Any one of the three largest federal employee health plan options by enrollment
- ▶ The largest HMO plan offered in the state’s commercial market by enrollment

States were required to choose their benchmark plans by December 26, 2012. If a state has not made a selection, a default plan will apply. The default plan for such states will be the largest plan by enrollment in the largest product in the state’s Small Group market.