State Benchmarks to Define "Essential Health Benefits" under Affordable Care Act

December 17, 2011

In a surprising move, the Department of Health and Human Services will not impose a uniform definition of "essential health benefits" (EHB) that individual and small group health insurance plans must provide in order to be offered on state exchanges starting in 2014.

Instead, as announced in a bulletin released on December 16, 2011, for 2014 and 2015 HHS will permit each state to define EHB, for coverage offered within that state, by reference to benefits provided under one of four benchmark plans:

- One of the state's three largest (measured by enrollment) small group plans
- One of the three largest (by enrollment) health plans for state employees
- One of the three largest (by enrollment) national health insurance options for federal employees; or
- The largest non-Medicaid HMO operating in the state's commercial insurance market.

Once a state chooses a benchmark plan, the services and items it covers would define the EHB package and carriers would have to provide "substantially equal" coverage – or better coverage — in order for their products to be offered on the state's exchange. The "substantially equal" standard allows for some variations among covered services, and quantitative limits, within a benefit category, so long as the changes do not reduce the value of coverage.

As a result of this decision, coverage that qualifies for state exchanges will vary from state to state, just as do state Medicaid and children's subsidized (CHIP) coverage programs. In that regard, however, the bulletin notes that small group plans, state employee plans and the two major federal government employee plans do not differ significantly in the range of services they covered, and generally offered all 10 categories of coverage required of an EHB. Greater similarities were noted in cost sharing among these types of plans, but the December 16 bulletin covers only the coverage components of EHB. The HHS reserves discussion of cost sharing, such as deductibles and co-pays, to a future announcement.

The Affordable Care Act requires that states defray the cost of state-mandated coverage in excess of the EHB package, so we may see efforts by states to "back into" the benchmark plan that incorporates the highest number of the state's benefit mandates. If a state failed to choose a benchmark plan, the default plan for that state would be the largest plan, by enrollment, in the largest "product" in the state's small group market — with "products" meaning services covered as a package by an issuer, which may have several cost-sharing options and riders as options.

By granting states the discretion to define EHB in this manner, the Obama administration has sidestepped one of the more controversial and logistically thorny features of the Affordable Care Act. To comprise EHB, 10 different categories of coverage must be

provided, including potentially costly (and thus often excluded) items and services such as mental health and substance use disorder services, pediatric oral and vision care, rehabilitative care, and habilitative care for conditions like autism. Legislators have struggled to formulate a uniform definition of EHB that covers all 10 categories while remaining "affordable" as mandated by the Act.

In October, the Institute of Medicine (IOM) issued a report recommending that the EHB package be keyed to cost and covered services under the "typical small employer plan in today's market." This medical community, by contrast, has pushed for a more comprehensive package of coverage similar to that enjoyed under large employer group plans. The Act itself requires that EHB resemble a typical employer plan, however with each of the 10 categories represented.

As with most aspects of the Affordable Care Act, there is a decidedly political angle to the EHB definition debate. Many supporters of the Affordable Care Act view a uniform federal definition of minimum essential health benefits as central to the legislation's groundbreaking reforms. However opponents of the Act have criticized the EHB definition as an inflexible, big-government intrusion in the traditionally state-governed area of health insurance.

It may be that the Administration chose the state-by-state course as a necessary evil – a way to preemptively defuse conflict over a uniform definition of EHB as we head into what promises to be a contentions election year.

The bulletin invites public comment on the proposals it contains; any such comments must be submitted to HHS by January 31, 2012. HHS will reassess the state benchmark approach for 2016 and subsequent years.

http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
http://books.nap.edu/openbook.php?record_id=13234