

# **Essential Health Benefits**

## **Background and Potential Decision Implications**

### **North Dakota Insurance Department**

#### **September 6, 2012**

#### **Background**

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (PPACA) charges the Secretary of the U.S. Department of Health and Human Services (HHS) with further defining Essential Health Benefits (EHB), and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. It requires all non-grandfathered health insurance plans offered in the small group and individual markets to cover all EHB by January 1, 2014. The EHB package must be included in plans inside and outside of the Exchange.

HHS has defined the requirements of an EHB benchmark package and described the method for states to choose an EHB package through a Bulletin issued on December 16, 2011 and other non-regulatory guidance. No formal rule has been released and, as of today, we do not know when the final rule will be issued or what type of specific information it will include.

#### **Making the Choice**

The current information provided to states lays out the following process.

1. The state determines the potential benchmark plans from the following four options as they existed on March 31, 2012:
  - a. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market (as suggested by HHS);
  - b. Any of the largest three state employee health benefit plans by enrollment;
  - c. Any of the largest three national FEHBP plan options by enrollment; or
  - d. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.
2. The State selects one of the benchmark health plans by September 30, 2012. (Recent indications from HHS are that this is a "soft" date.)
3. The Secretary will review the choice to determine if the plan:
  - a. Meets the requirement for coverage in ten broad categories of health benefits: 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.
  - b. Reflects typical employer health benefit plans reflects balance among the categories;
  - c. Accounts for diverse health needs across many populations;
  - d. Ensures there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
  - e. Ensures compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);

- f. Provides states a role in defining EHB; and
  - g. Balances comprehensiveness and affordability for those purchasing coverage.
4. Should a state not choose a benchmark plan, the default benchmark plan would be the small group plan with the largest enrollment in the state.
  5. The chosen plan would be the benchmark for the years 2014 and 2015. HHS intends to review and update EHB for 2016 and beyond.

### **Plan Benefits**

The benefits covered in the chosen plan become the EHB package for that state, subject to the addition of any missing categories. For example, most health insurance plans do not include pediatric dental services which are a required category of EHB. Limits in the scope and duration of benefits in the benchmark plan are incorporated in EHB requirements. However, there can be no dollar value limits on EHB benefits. If an insurer wants to substitute a service for an EHB required category of benefits, the substitution must be actuarially equivalent. Cost sharing requirements are not considered a part of the EHB definition and are separately regulated under the PPACA.

In designating a benchmark, the state is designating that benchmark plan's benefit package as the minimum benefit package required for all non-grandfathered small group and individual plans sold in North Dakota. If the designated benchmark plan does not include benefits in all ten required EHB categories, the state must supplement the benchmark plan by selecting missing benefits from other benchmark options or from the state's Children's Health Insurance Program (CHIP). States may only supplement benefits that are not covered in the benchmark or the state must pay for any added mandates. State mandate laws still apply.

### **Potential Decision Implications**

States may choose any plan in the benchmark options. Some of these plans are considered more basic in the coverage of benefits and others richer. All of the North Dakota benchmark choice plans will require additional benefits to be added to them to meet the ten required categories and all must be modified to take out the dollar limits on the existing benefits.

Specific coverage that is included in specific plans may cause a plan to be more or less expensive as it relates to the premium cost of that particular coverage, i.e., coverage for certain fertility benefits with no dollar limitations is a more expensive benefit to add to plans than certain laboratory services without dollar limitations.

Given that all non-grandfathered small group and individual plans must include the EHB benefits after 2014, this set of benefits is often thought of as a floor. Insurers may add to those benefits in any way they like (and price the products accordingly), but they may not take benefits away.

The impacts of choosing a basic plan versus a rich plan are various and include potential premium pricing increases, premium value as it compares to the necessity of specific coverage, market disruption, insurer competition, network adequacy and provider payments.

Choosing a richer plan, especially given no dollar limitations, will most likely cause most existing insurers to request higher premium rate increases due to the additional benefits likely to be paid. Affordability becomes a serious concern for policyholders.

Some policy holders may want to know most benefits are covered by their plans, thereby wanting a rich plan. Choosing a richer plan may force employers and individuals to purchase insurance they do not want or need.

Choosing a basic plan in a state like North Dakota where most of the existing small group and individual plans have traditionally been fairly rich may cause market disruption. Small employers may terminate previous, richer plans especially if the more basic plans cost less. This may leave employees with far fewer benefits than previously or without an employer-sponsored plan at all.

A perceived positive impact of choosing a basic plan is that it would allow insurers to design plans in a unique way to compete against other insurers by adding select benefits that distinguish one plan from another. This would also allow for better variation when employers and individuals shop for insurance whether inside or outside of the Exchange.

Certain areas of the state may not have adequate provider networks for all benefits in a rich plan. Just because the benefit is covered doesn't mean every policyholder will be able to take advantage of that coverage easily.

Providers are likely to want more benefits covered instead of fewer because insurance is a better payer than an individual who has to pay for his/her own services, Medicaid or Medicare.

There are likely more potential positive and negative impacts of the various EHB benchmark choices specific to unique groups of consumers, employers and insurers.