

Connecticut Health Insurance Exchange

Overview of Essential Health Benefits

- The ACA requires health insurance plans offered through state exchanges to cover a specific level of preventive, diagnostic, and therapeutic services defined as “essential” by HHS.
- Health insurance plans not covering these services will not be considered adequate health insurance. Owners of such plans will be subject to a penalty as if they did not have coverage.
- HHS guidance bulletin provides a “transition period” for 2014 and 2015 allowing states to establish state-specific “benchmark plan” designed to reflect core services of a “typical employer plan” in their state. Benchmark plan would accommodate existing state mandates, and federal subsidies will be adjusted to reflect variability of different state benchmark plans.
- States that do not select a benchmark plan will default to a benchmark plan representing the plan with the highest enrollment in the largest product in the state’s small group market.
- HHS asked the Institute of Medicine (IOM) to recommend a process that defines EHB coverage and updates EHB coverage based on scientific advancement and its impact on the cost of benefit changes.

Background

- EHB must be “equal to the scope of benefits provided under a typical employer plan as determined by the Secretary of HHS. EHB must include at least 10 categories of services:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Rx
 - Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care
 - Mental health and substance abuse disorder services, including behavioral health treatment
- ACA does not guide the Secretary of HHS to determine basis on which benefits could be determined *non-essential* with the exception of limitations to the Secretary’s ability to *exclude* benefits.

Four Options for Benchmark Plans for 2014 and 2015

1. Largest plan by enrollment in any of the three largest small group products in state’s small group market
2. Any of the largest three state benefit plans by enrollment

3. Any of the largest three national Federal Employee Health Benefit Program (FEHBP) plan options by enrollment
4. Largest insured commercial non-Medicaid HMO operating in state (often a BCBS plan)
 - If a state does not select a benchmark plan, HHS proposes that the default benchmark plan be the largest enrolled plan in the largest product in the state's small group market.
 - If a state chooses a benchmark plan with state mandates, those mandates will be included in the state EHB package. If a state selects FEHBP as a benchmark, which may not include state mandates, the state will be required to cover the cost of mandates outside of the state EHB package.
 - If a state EHB plan doesn't cover any of 10 care EHB categories (e.g. pediatric oral or pediatric vision services), the state must supplement missing categories using benefits from any other benchmark option

Institute of Medicine Recommendations

- IOM asked to make recommendations on a process for determining and updating EHB, not to determine specific health benefits.
- Given two-year transition period proposed, HHS has additional two years to study IOM recommendations in the context of benchmark plans selected by the states.
- IOM considered how four policy domains could guide formulation of basic EHB benefits:
 - Economics
 - Ethics
 - Population-based health
 - Evidence-based practice
- IOM determined that costs and premium affordability must be considered in determining initial EHB coverage and its updating.
- IOM defined a "typical employer plan" as a typical small employer's benefit plan.
- IOM proposed EHB should be modified to meet an estimated premium target, and that state exchanges have flexibility to design a variation of EHB if certain standards are met.
- IOM believes EHB should become evidence-based, value-based, and specific over time, and that any services added to EHB should be offset by savings, either through medical management or via the elimination of an outmoded service.

Other Issues for Consideration

- Impact of Medical Trend
 - As premium costs increase for EHB coverage, the federal government's costs for advanced premium tax credits rises. This is because the ACA limits how much low-to-moderate income individuals pay for coverage.
 - Unless contribution limits for low and moderate individuals rise with medical inflation, medical trend increases will be born essentially by the federal government. May impact how HHS creates EHB guidance for 2016 and beyond.

- Transition Period
 - The HHS bulletin underscores how 2014 and 2015 are a “transition period” for states to consider impact of benefit mandates and delaying the cost of subsidizing those mandates beyond a uniform definition of EHB
 - Given expense of federal subsidies for state benchmark plans with rich mandates, it is likely in 2016 and beyond that federal subsidies for mandate-rich EHB plans will diminish. States may need to confront the affordability of subsidizing these mandates.