Health care reform at-a-glance

Essential health benefits

The Affordable Care Act (ACA or health care reform law) requires fully insured small group and individual plans to cover an essential health benefits (EHB) package starting in 2014. This rule applies to nongrandfathered plans sold inside and outside the health insurance exchanges.

Current guidance indicates large group and self-insured plans do not need to provide coverage for EHB, but if they choose to do so, they cannot have an annual or lifetime dollar limit on those benefits.

The law outlined general categories that must be included in the EHB package, but left it up to the Department of Health and Human Services (HHS) to define which services are considered EHB. To assist with this effort, HHS asked the Institute of Medicine (IOM) to make recommendations regarding the process for defining and updating the EHB package.

In its response, the IOM focused on how the selection criteria should strike a balance between affordability and comprehensive benefits. For more details on IOM’s recommendations, see Essential Health Benefits: Balancing Coverage and Cost.

On December 16, 2011, HHS published the Essential Health Benefits Bulletin (Bulletin). The Bulletin proposed an approach that makes the states responsible for selecting a benchmark to define the EHB package for their states. With this approach, states would select one of these four options to create a benchmark for defining EHB:

- The state’s largest plan by enrollment in any of the three largest small group products;
- One of the state’s top three state employee plans;
- One of the state’s top three national Federal Employee Health Benefit Program (FEHBP) plans; or
- The state’s top HMO commercial plan.

If the benchmark plan does not include all of the required EHB categories outlined in the health care reform law, these services will need to be added. The Bulletin provides guidance on how the states should go about supplementing their selected benchmark plan under these circumstances.

If a state does not select a benchmark for its EHB package, the federal default is the largest plan in the small group market with the largest membership.

On December 16, 2011, the Department of Health and Human Services released a Bulletin proposing that states pick one of four options to create a benchmark for defining the essential health benefits (EHB) package. With this approach, HHS is proposing to make the states responsible for defining what should be included in the EHB package.

At this time, employers do not need to take any action such as modifying benefit plans. We are analyzing rules and bulletins from the HHS and will update you if any action is needed as we prepare for the 2014 implementation of health care reform.
On January 25, 2012, HHS also released [Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State](#). This list complements the EHB bulletin and provides the following information:

- A list of the products with the three largest enrollments in the small group market in each state using data from healthcare.gov
- The names of the three largest products in each state ranked by enrollment
- The top three nationally available FEHBP plans based on enrollment

HHS released a frequently asked questions document on February 17, 2012 with the following clarifications:

- State-selected EHB can only include benefits in place as of December 31, 2011 for 2014 and 2015 (benefits and mandates added after this must be funded by the state).
- One of the four benchmark plans may be used for large group plans to define EHB that may not include annual or lifetime dollar limits.
- Benefits that are covered under a rider in a benchmark plan are not considered part of the EHB package.
- If a state selects the largest small group plan as its benchmark, a state should look at the second- and third-largest small group market benchmark plans and then FEHBP when they need to supplement a benchmark plan that does not include any of the 10 statutory EHB categories in the ACA. If a state selects a different benchmark, it will likely look at the largest small group plan first to supplement the benchmark for any missing categories of services.
- States would select one benchmark for both the individual and small group markets.
- The distinctions used on healthcare.gov will determine the difference between a plan and product. However, HHS will work with states to resolve any differences as to what the state thinks are the largest three products.
- Nondollar limits in a benchmark plan, such as visit limits, become part of the EHB. However, plans can modify these limits as long as the resulting benefit is actuarially equivalent.
- Federal mental health parity requirements would apply to the EHB.
- States would need to select benchmark plans by the third quarter of 2012 using a standardized format to be provided by HHS.
- States could offer Medicaid expansion populations a different benchmark plan than the one selected for the individual and small group markets. The package could be the traditional Medicaid benefit package. States must ensure that the Medicaid expansion population receives benefit in each of the 10 statutory categories in the ACA.

**Questions and answers**

**Q.** If a company has employees in multiple states, which state’s EHB package does it offer as part of its coverage?

**A.** According to the FAQs released by HHS on February 17:

- The applicable EHB benchmark for the state where the insurance policy is issued would determine EHB for all members, regardless of the state where they live.
- Employers that are not required to offer EHB would comply with the applicable annual and lifetime limits rule. This includes grandfathered health plans and large group market coverage.
Q. If a state mandates certain coverage, does this need to be included as part of the EHB?
A. If a state mandate is included in the selected benchmark plan, it will become an EHB. This only applies to mandates in effect in 2011. Mandates passed in 2012 and after will not be considered EHB under the proposed approach.

Q. If a state does not choose a benchmark for the EHB, what happens?
A. According to the Bulletin, if a state does not select a benchmark for EHB, the federal default is the largest small group product in the state. However, it is not clear when the default will be triggered.

Q. What types of plans are required to cover EHB?
A. Nongrandfathered, fully-insured plans in the individual and small group markets both inside and outside of the exchanges along with certain other types of plans must cover EHB beginning in 2014. Current guidance does not indicate that large group and self-insured plans will need to include the EHB package. However, if these plans offer benefits considered to be an EHB, they are prohibited from putting an annual or lifetime dollar maximum on those benefits.

Q. For the lifetime limits provision that took effect in 2010, which services did you consider essential health benefits?
A. Good faith compliance is required until we receive final regulations. The following is a list of services we believe may be defined as essential health benefits and therefore we have removed existing limits on these benefits. Please note that benefits may vary by state. The federal health care reform law does not require coverage for the essential health benefits package at this time, but this coverage will be required in 2014 for certain markets.

- Allergy injections and/or testing
- Ambulance
- Ambulatory surgical services
- Asthma education
- Bariatric surgery
- Cardiac rehab
- Chiropractic manipulation services and/or osteopathic manipulation
- Diabetic supplies and glucometers
- Diagnostic services
- Dialysis and kidney disease treatment
- Durable medical equipment, medical equipment and supplies, oxygen
- Emergency room services
- Enteral formula and modified low protein food products
- Hearing aids
- Home health care
- Hospice
- Infusion therapy, home infusion therapy
- Inpatient or outpatient facility services
- Inpatient rehab/physical therapy
- Maternity
- Mental health/substance abuse inpatient and/or outpatient
- Office visits
- Ostomy supplies
- Outpatient occupational therapy
- Outpatient physical therapy
- Outpatient speech therapy
- Pharmacy and prescription drugs/injections
- Preventive care and preventive screenings
- Prosthetic devices or limbs
- Pulmonary or respiratory rehab/therapy
- Skilled nursing
- Surgical and anesthesia services
- Transplant services
- Treatment of TMJ

Please note that the listed services still may be subject to copays and other cost shares.
Once we get further definition on EHB, we may adjust some of the actions we have taken and information we have provided to our customers.

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