Health Advocate

E-Newsletter of the National Health Law Program

Volume 40 August 2015

Essential Health Benefits Overview

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Key Resources

Essential Health Benefits Update and Advocacy Opportunities Available

NHeLP's Essential Health Benefits Prescription Drug Series

Lessons From CA: Essential Health Benefits

Coming in September *Health Advocate*: Preview of Open Enrollment

Introduced by the Affordable Care Act (ACA), Essential Health Benefits (EHB) are a set of ten health care service categories that certain health plans must cover.[1] In February 2015, the Department of Health and Human Services (HHS) issued the *Notice of Benefit and Payment Parameters for 2016 final rule* (Final Rule 2016), which finalized changes to the EHB standard.

In the Final Rule 2016, HHS announced that new EHB base-benchmark plans would be selected for the 2017 plan year. HHS will soon publish a list of the benchmark plans for each state. Once the list is published, there will be a comment period when the public will have an opportunity to review plan documents for the state's EHB base-benchmark plan and raise any concerns before there is final federal approval.[2]

This month's *Health Advocate* offers an EHB overview in anticipation of HHS' posting of the benchmark plan list and public comment period.

Selecting an EHB Base-Benchmark Plan

States select one of ten coverage options (referred to as "base-benchmark" plans) as a reference plan to define EHBs in the state. When selecting a base-benchmark plan (BBP), the state is not selecting the actual plan, but rather the list of benefits that health plan offers.

The BBP options are:

- the three largest Federal Employees Health Benefits Program plans;
- the three largest state employee plans;
- the three largest small group plans in the state; or
- the HMO plan with the largest commercial, non-Medicaid enrollment in the state.

[1] This publication focuses on EHBs as they apply to the private market. The EHB requirement applies to non-grandfathered health plans offered in the individual and small group markets (both inside and outside the Marketplace). Self-insured group health plans, large group market plans, and grandfathered health plans are not required to provide EHBs.

[2] Plan documents will include data and information regarding all health benefits in the plan, treatment limitations, drug coverage, and exclusions. 45 C.F.R. § 156.120(b)(2).

States that do not select a BBP get assigned the default benchmark, which is the largest small group plan, by enrollment, in the state. For the 2016 plan year, the BBP selected (or assigned by default) in 2012 will continue to apply. However, states may select a new BBP for the 2017 plan year from the same ten options listed above, but based on 2014 plans. HHS asked states to submit their EHB BBP selection by June 1, 2015, although some states got approval for an extension.

Ensuring the 10 EHB Categories Are Covered

The state's BBP must cover items and services in the ten Essential Health Benefit categories.

EHB 10 Statutory Categories of 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 (including chronic disease management)
- pediatric services, including oral and vision care

Supplementing

If the EHB BBP selected by a state does not include items or services in any one of the 10 EHB categories, the BBP must be supplemented by adding that particular category in its entirety from one of the other EHB BBP options. There are some exceptions to this general supplementing rule; for example, pediatric oral and vision care have their own supplementing methodology.

Pediatric Oral Care

Supplement with:

- the Federal Employees Dental and Vision Program (FEDVIP) dental plan with the largest enrollment, or
- dental benefits available under the state's separate Children's Health Insurance Program (CHIP) plan.

Pediatric Vision Services

Supplement with:

- the FEDVIP vision plan with the largest national enrollment, or
- vision benefits available under the state's separate CHIP plan.

Substitution

Unless prohibited by state law, issuers offering EHB may substitute benefits that are: 1) actuarially equivalent to benefits replaced, and 2) within the same EHB category. Therefore, covering EHBs means the health plan provides benefits "substantially equal" to the EHB BBP. This can lead to problems because health plans can replace services that certain populations may need (*e.g.*, individuals with chronic conditions) with actuarially equivalent services, which may be less costly and more likely to attract healthier populations.

States have the option to adopt more stringent standards that limit or prohibit this type of substitution. In states not prohibiting substitution, consumers may find it difficult to compare health coverage options, which can make plan selection challenging.

Covering Habilitative Services

The Final Rule 2016 changed the rules for covering habilitative services. HHS established a uniform definition of habilitative services, to be used beginning with the 2016 plan year, in order to minimize: 1) variability in how the benefit is covered, and 2) lack of coverage of habilitative services versus rehabilitative services.

> **Uniform Definition of Habilitative Services**
>
> Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

If the EHB BBP selected does not provide coverage of habilitative services or provides inadequate coverage, states may define the benefit, but must use the uniform definition as a minimum standard. If the state does not define the benefit, issuers will cover habilitative services and devices as defined in the uniform definition. Thus, the Final Rule 2016 ***removed*** issuers' flexibility to define this benefit.

In addition, issuers required to provide EHB cannot impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices. Beginning in plan years on or after January 1, 2017, issuers will be required to impose separate limits on habilitative and rehabilitative services and devices.

Raising the Pediatric Services Age Limit

In the Final Rule 2016, HHS also clarified that beginning on or after January 1, 2016, pediatric coverage *must be provided* until the end of the month in which the enrollee turns 19 years of age. Note, however, that the February 2013 EHB Final Rule gives states the flexibility to extend pediatric coverage beyond the 19-year age baseline, and this option continues to exist.

Advocates have been urging states to take the option to raise the age limit for pediatric services to at least age 21, which aligns with existing standards for Medicaid and ensures that children continue to receive pediatric services until age 21.

State Mandated Benefits

If a state requires a Qualified Health Plan to offer benefits in addition to those included in the EHB BBP, the state has to defray the cost of covering the additional benefits. However, state benefit mandates enacted on or before December 31, 2011 (even if not effective until a later date) are considered part of the EHB; therefore, states do not have to defray the cost of covering those benefits. By contrast, states are expected to defray the cost of state benefit mandates enacted on or after January 1, 2012, unless those mandates were required to comply with new federal requirements. In the Final Rule 2016, HHS clarified that state benefit mandates enacted in order to define habilitative services are part of the EHB, so states do not have to defray the cost for those mandated benefits.

Enforcing the Non-Discrimination Provisions of the ACA

With respect to EHBs, the ACA and implementing regulations prohibit issuer discrimination in benefit design or implementation. An issuer does not provide EHBs if "its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." (45 C.F.R. § 156.125.)

In the preamble of the Final Rule 2016, HHS gave three examples:

> (1) attempts to circumvent coverage of medically necessary benefits by labeling the benefit as a "pediatric service," thereby excluding adults; (2) refusal to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal; and (3) placing most or all drugs that treat a specific condition on the highest cost tiers.

HHS stated that these practices are potentially discriminatory, especially if there is no appropriate non-discriminatory justification for the plan design. (Final Rule 2016 at 10,822-23.)

New EHB Prescription Drug Standards

The Final Rule 2016 significantly modified EHB prescription drug requirements. Please see NHeLP's EHB Prescription Drug Series for an overview of changes made to the EHB prescription drug standard and advocacy opportunities and strategies to help ensure that low-income and underserved populations can obtain the prescription drugs they need.

Conclusion

When HHS publishes the list of EHB base-benchmark plans for the 2017 plan year, advocates and stakeholders should be prepared to review plan documents and comment on the state's proposed EHB base-benchmark plan during the public comment period that follows. This public review period offers the opportunity to review the state's EHB base-benchmark plan for compliance with the HHS rules described in this publication and raise any concerns identified with both the state and HHS before final federal approval. NHeLP will release additional fact sheets on EHBs to assist advocates and other stakeholders in the review process, so please visit our website regularly for more information.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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