

MEMORANDUM

To: Association of Academic Psychiatrists

From: Peter W. Thomas; Theresa T. Morgan; Kristen Piehl

Date: December 20, 2011

Re: HHS Releases Essential Health Benefits Bulletin

Overview

On December 16, 2011, the Department of Health and Human Services (HHS) released a critical [bulletin](#) outlining the agency's proposed strategy for regulating the essential health benefits (EHB) package. Starting in 2014, the Patient Protection and Affordable Care Act (ACA) requires all qualified health plans (all non-grandfathered small group and individual plans offered both inside and outside of state Exchanges) to cover ten categories of essential benefits. The bulletin, which is not a regulation but instead provides non-binding guidance in advance of regulations, surprised many stakeholders because HHS chose to forgo defining a federal minimum benefit package, at least for now. Instead, HHS proposes to allow each state to create its own essential benefit package linked to a "benchmark" plan adopted by each state. This benchmark plan will also affect that states coverage under a new category of Medicaid beneficiaries.

HHS outlines an approach similar to that used by the Children's Health Insurance Program (CHIP). States can select as their benchmark plan:

- the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market; or
- any of the three largest State employee health benefit plans by enrollment; or
- any of the three largest national plan options offered to federal employers (FEHBP); or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS plans to evaluate the EHB benefit packages and the benchmark approach, and requests feedback on evaluation processes. In particular, HHS will assess benefit access, changes in

medical evidence or scientific advancement, market changes not reflected in the benchmarks and the affordability of coverage as it relates to EHB. HHS issued the bulletin prior to regulation to offer much-needed guidance to states that must begin legislative activity to ensure the health insurance exchanges and qualified health plans are operational in 2014. HHS will accept comments on the bulletin until January 31 at: essentialhealthbenefits@cms.hhs.gov. Future guidance and regulation will address cost-sharing and the relationship between the EHB package and Medicaid.

Defining the Scope of Essential Health Benefits

In its analysis of the Federal Employees Health Benefits Program (FEHBP), Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA), HHS found that plans do not differ significantly in the range of services they cover. HHS found that many benefits are consistently covered across markets (and are expected to be included in benchmark plans), including:

- Physician and Specialist visits;
- Hospitalization;
- Organ transplants;
- Inpatient and Outpatient Mental Health and Substance Use Disorder services;
- Physical, Occupational and Speech therapy;
- Durable Medical Equipment; and
- Orthotics and Prosthetics.

HHS proposes that health plans be allowed to offer benefits that are “substantially equal” to the benefits of the benchmark plan selected by the State, and modified as necessary to reflect the 10 coverage categories. HHS is considering whether to allow substitutions within each of the 10 categories and across the benefit categories. HHS would require that the substitution be “actuarially equivalent” to the benefits listed in the benchmark package. HHS seeks input on whether substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories.

Incorporating State Mandates into Benchmark Plans

The bulletin does not provide guidance on whether states should incorporate their benefit mandates into their benchmark plan. Rather, it provides some insight into when a state would be responsible for the extra cost of mandated benefits in excess of the EHB, as required by the ACA. HHS proposes a “transition period” in 2014 and 2015 during which HHS will assess how states incorporate mandates into the EHB. During those two years, if a state chooses a benchmark subject to state mandates – such as a small group market plan – that benchmark would include those mandates in the state EHB package, meaning federal subsidies would help cover the cost of the state mandate those first two years. Alternatively, a state could also select a benchmark such as an FEHBP plan that may not include some or all of the state’s benefit mandates, and therefore the state would be required to cover the cost of those mandates outside the state EHB benchmark package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude (presumably because of cost

or other variables) some state benefit mandates from the minimum EHB package.

Rehabilitation, Habilitation, Mental Health Services and Pharmacy Benefits

The ACA lists “rehabilitative and habilitative services and devices” as a mandatory essential health benefits category. In the bulletin, HHS gives limited guidance on the scope of benefits covered within the category. Also, HHS only briefly addresses ACA requirements that in regulating the EHB, HHS should:

- reflect an appropriate balance between the ten categories;
- account for the diverse health needs across many populations; and
- ensure there are no incentives for coverage decisions...to discriminate impermissibly against individuals because of their age, disability, or expected length of life.

Although the bulletin does not offer a definition of rehabilitation, HHS describes the focus of rehabilitation services as services for individuals to relearn or restore existing skills or functions. The guidance does not describe rehabilitation’s ability to help an individual maintain or prevent deterioration of function after onset of illness or injury.

In the bulletin, HHS declines to provide a definition of habilitation. The agency notes that the NAIC has proposed a definition of habilitation and that Medicaid has also adopted a definition of habilitative services, and that these definitions include the concept of “keeping” or “maintaining” function. HHS seeks comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services, and is considering two options if a benchmark plan does not include coverage for habilitative services:

- 1) Habilitative services would be offered at parity with rehabilitative services -- a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or
- 2) As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future.

Regarding mental health and substance abuse services, HHS intends to propose that health insurance “parity” applies in the context of EHB. All benchmark plans must include coverage for mental health and substance use disorder services, including behavioral health treatment.

In terms of the pharmacy benefit, HHS proposes to require plans to cover certain categories and classes of drugs listed in the benchmark plan, but would allow plans to choose which drugs to offer within each category. Drug category and class lists would be provided by U.S. Pharmacopoeia, Allied Health Medical Support, or through a similar standard. If a benchmark plan offers a drug in a certain category or class, all plans would be required to offer at least one drug in that same category or class, even though specific drugs on the formulary may vary. Although HHS intends this standard to reflect the flexibility permitted in Medicare Part D, HHS does not intend to adopt the protected class of drug policy in Part D.