01/12/11 - Essential Benefits

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Background

Federal Regulation of Health Insurance Benefits

Prior to the enactment of the Affordable Care Act (ACA), federal law did not specify a standard minimum benefit package that must be covered by private health insurance and group health plans. Federal law did, however, address benefit coverage in a few areas.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act requires plans that provide mental health or substance addiction coverage to provide parity in those services as compared to other covered medical or surgical benefits.[1] Under the law, enrollee out-of-pocket costs (i.e., deductibles and co-pays or coinsurance) and coverage limits, such as number of visits or days of coverage for mental health and substance abuse, may be no more restrictive than those requirements for other covered medical or surgical benefits.[2] The 2010 amendments to the Act and resulting regulations expand the nondiscrimination provisions, applying them to non-quantitative limits such as benefit design and utilization management techniques that restrict treatment for mental illness and addiction disorders that are not based on medical evidence.[3] The regulations also clarify that plans may not impose medical necessity criteria that utilize more restrictive tests, such as tiered cost-sharing, tiered network arrangements and utilization management procedures that result in discrimination.[4]

The Newborns and Mothers Protection Act requires health plans to provide hospital coverage to mothers and newborns following delivery. Under the law, plans must cover hospitalization for at least 48 hours following a normal delivery and 96 hours following a cesarean section.[5]

Similarly, the Women's Health and Cancer Rights Act (WHCRA) requires plans that cover mastectomies to cover breast reconstruction surgery and other treatments related to mastectomy.[6]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) did not address health insurance benefit design and coverage rules. At the same time, HIPAA limited the authority of group health plans (whether fully insured or self-insured) to deny coverage or impose pre-existing condition exclusions and

prohibited the application of enrollment bans and pre-existing condition exclusions for individuals who had previously been enrolled in group coverage and who remained continuously enrolled through COBRA.[7] The law did not, however, prevent plans from imposing coverage limits for enrolled individuals, nor did it prevent plans from charging significantly higher premiums to individuals or groups with higher risk enrollees.

State Regulation of Health Insurance Benefits

States generally regulate coverage of insurance benefits as a condition of state licensure. While there are a few exceptions, particularly in states such as Massachusetts, that have sought to enact more comprehensive health reform laws, state laws generally focus on covering specific types of providers or types of treatments and procedures, or treatments furnished by specific providers, rather than seeking to define a comprehensive benefit package.[8] As of 2009, according to a report by the Council for Affordable Health Insurance, states had enacted more than 2,100 specific coverage requirements related to providers, treatments, procedures, or services.[9] State benefit mandates represent important protections in the view of consumer and patient advocacy groups because they assure that certain treatments that otherwise might be excluded will in fact be available. At the same time, benefit mandates historically have raised cost concerns among employers and insurers.[10]

Federal Protections Against Discrimination

A number of federal laws address discrimination on the basis of health status.[11] The Americans with Disabilities Act protects "qualified persons with a disability" from discrimination in public programs and in public accommodations, as well as in private employment.[12] Section 504 of the Rehabilitation Act protects "qualified handicapped persons" from discrimination in federally assisted programs.[13] An individual must meet the legal definition of disability or handicap in order to be protected and will not qualify for protection solely on the basis of poor health status.[14] While the ADA and Section 504 may prevent insurance plans from refusing to sell products to qualified persons with disabilities, courts have ruled that neither law by itself prohibits plans from designing benefits and coverage and cost-sharing rules that reduce the value of coverage for persons with disabilities or that exclude certain types of treatments or conditions from coverage entirely.[15]

Cost-sharing and Access

In recent years health plans, in order to reduce their costs, have imposed or

increased enrollee cost-sharing. Plans use this tool to require patients to pay a larger share of their health care costs or to incentivize patients to use what plan administrators believe to be more efficient provider networks or services.[16] Studies have shown that higher cost-sharing reduces patient utilization of services; at the same time, when not properly designed, higher cost sharing can deter use of medically necessary and appropriate care that in turn may have a longer-term detrimental effect on patient health and may ultimately result in higher costs.[17]

Even relatively low cost-sharing requirements can make consumers more cost conscious; however, they have been shown in some cases to discourage patients from seeking preventive care services.[18] By contrast, high out-of-pocket medical costs can pose serious financial hardship for insured families and if not properly designed can result in delay of not only primary care and preventive services, but also deferral of medically necessary care generally, including prescription drugs.[19] Some plans are now experimenting with "value based benefit design," which is intended to reduce cost sharing for treatments and services, such as prescription drugs, that can help maintain health and avert more serious disability and illness.[20]

Changes Made by the Health Reform Law (P.L. 111- 148, § 1302)

Defining essential benefits for health plans sold in Exchanges, as well as individual and small group health plans sold in the non-exchange market

The ACA not only bars discrimination in enrollment or the availability of coverage based on health status, but also establishes a minimum standard of coverage that must be satisfied by individual and small group health plans sold in both exchange and non-exchange markets, as well as by any qualified health plan sold in the state exchange market, regardless of group size. (For a full discussion of health plan requirements, see the GPS Implementation Brief on grandfathered health plans.) This minimum standard of coverage is known as an "essential benefit" package. Its purpose is to assure greater standardization in coverage while limiting the ability of insurers to use benefit design to discourage the enrollment of individuals who have medical conditions that may result in higher utilization of services.[21]

- The ACA requires the Secretary of the Department of Health and Human Services (HHS) to define "essential benefits" that must be offered by plans offered in the individual and small group health insurance markets.
- Beginning January 1, 2014, qualified health plans sold in health

insurance exchanges must cover all essential benefits.[22] In addition, new plans sold in the individual and small group markets must cover essential benefits, regardless of whether plans are sold inside or outside of state health insurance exchanges.[23]
• For the purpose of determining whether a plan must offer essential benefits, the law defines the term "small employer" as an employer who employs an average of not more than 100 employees during a year.[24] For plan years beginning before January 1, 2016, states may define small groups as 50 employees or fewer.[25]
• Plans that retain their grandfathered status are not required to offer essential benefits. ERISA is amended to extend the essential benefits requirement to all small ERISA group plans; at the same time, large insured ERISA groups as well as self-insured ERISA group health plans including multi-employer welfare arrangements (MEWAs), are exempt from the essential benefit requirements.[26]

The essential benefit statute sets forth a series of broad benefit classes that the Secretary's definition must include, and also sets forth important rules for developing essential benefit standards:[27]

• The following benefit classes are identified as essential benefit classes

• 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
• Pediatric services, including oral and vision care

Several important rules also apply when defining the benefits:

• In defining and periodically updating essential benefits, the Secretary must ensure that the "scope" of benefits is equal to the scope of benefits provided under typical employer and multiple employer plans, as defined by the Secretary. To help inform the Secretary's decision, the Secretary of Labor is directed to conduct a survey of employer-sponsored coverage and report its findings to the Secretary of HHS.[28] In defining essential benefits, the law requires the Secretary to provide notice and opportunity for public comment and must report to Congress.
• There are also a series of additional requirements with respect to the definition of essential health benefits:[29]

• *Balance among benefits*: The Secretary must ensure that the benefits reflect an appropriate balance among the categories of benefits.
• *Anti-discrimination*: The Secretary is prohibited from making coverage decisions, determining reimbursement rates, establishing incentive programs, or designing benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.
• *Special needs populations*: In defining essential benefits, the Secretary is required to take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.
• *Benefit denial based on certain factors*: The Secretary must ensure that essential benefits are not subject to denial to individuals against their wishes on the basis of individuals' age or expected length of life, the individuals' present or predicted disability, degree of medical dependency or quality of life.
• *Emergency care*: The Secretary may not treat a "qualified health plan" as meeting the essential benefit requirements unless the plan provides for coverage of emergency department services without requiring preauthorization of services or limits on coverage related to whether or not the plan has a contract with providers. In addition, cost-sharing must be the same, regardless of whether services are provided in or out of network.
• *Stand-alone dental benefits*: The Secretary must assure that, in an

Exchange in which a plan offering stand-alone dental benefits, all plans would not be required to offer stand-along dental benefits.
• *Report to Congress*: The Secretary must periodically review the essential benefits and provide a report to Congress that contains the following:

• An assessment of whether enrollees have difficulty accessing need services for reasons of coverage or cost;
• Whether essential benefits need to be modified or updated to account for changes in medical evidence or scientific advancement;
• Information on how benefits will be modified to address gaps in access or changes in the evidence base;
• An assessment of potential of additional or expanded benefits to increase costs and any interactions between the additional or expanded benefits and reductions in existing benefits to meet statutory limits on the actuarial values of plans; and
• Periodically update the essential benefits to address gaps in coverage or changes in the evidence base.

• *State mandated benefits, inside and outside exchanges*: The law includes language clarifying that plans are not prevented from offering benefits in excess of those defined as essential benefits.[30] In addition, states may require qualified health plans sold in exchanges to cover additional benefits not included in the essential benefit package; however states that do so will be required to pay the costs associated with the additional requirements.[31] In the case of health plans sold by insurers in the non-exchange individual and small group markets, which are subject to the essential benefit requirement as well, a state's benefit mandates would continue to apply, with costs included in the premium, unless the state were to eliminate its benefit mandates in the non-exchange market.
• *Utilization management*. The ACA prohibits the Secretary from limiting health plans ability to impose "utilization management techniques" that were in effect as of the date of enactment of the ACA.[32]

Annual Cost-Sharing Limits for Health Plans Subject to Essential Benefit

Requirements

For the plan year beginning in 2014, cost-sharing for self-only and family coverage may not exceed the amount established under section 223(c)(2)(A)(ii) of the Internal Revenue Code, which is the cost-sharing limit for high-deductible health plans. For 2014, that amount is limited to $5,950 for an individual and $11,900 for a family. For plan years beginning in 2015 and later cost-sharing is limited to:

- For self-only coverage, the amount established for 2014, plus the product of the 2014 amount and the "premium adjustment percentage" established for the calendar year.
- For other coverage, cost-sharing is limited to twice the amount of self-only coverage.
- Cost-sharing limits are rounded down to the next lowest multiple of $50.

Cost-sharing is defined to include deductibles, coinsurance, copayments or similar charges and any other expenditure required of an insured individual (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to covered essential health benefits.[33]

In the case of deductibles, the law provides that plans sold after January 1, 2014 in the small group market and subject to essential benefit requirements may not impose deductibles that exceed $2,000 for a single individuals or $4,000 for families.

- The plan deductible amount may be increased by the maximum amount of reimbursement available to individuals under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement). For plan years beginning after 2015, the deductibles are indexed for inflation.

Levels of Coverage for Qualified Health Plans Sold in Exchanges as well as Health Plans that are Subject to Essential Benefit Requirements[34]

Section 1302(d) establishes the four levels of coverage (Platinum, Gold, Silver, and

Bronze) for qualified health plans sold in exchanges as well as health plans generally subject to the essential benefits requirement.

- The Bronze Level must "provide coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan."[35]
- The Silver Level must provide coverage equal to 70% of the full actuarial value.[36]
- The Gold Level must provide equal to 80% of the full actuarial value.[37]
- Finally, the Platinum level must provide coverage equal to 90% of the full actuarial value.[38] The actuarial value will be based on the essential health benefits defined by the Secretary of the Department of Health and Human Services.[39]
- The law also specifies a catastrophic health plan that does not provide bronze, silver, gold, or platinum coverage will meet the requirements of subsection (d) if the plan is only offered in the individual market and the individual is under 30 years of age or has obtained a hardship certification under section 5000A of the Internal Revenue Code of 1986.[40]

Special Rules Related to the Coverage of Abortion Services in the Case of Qualified Health Plans Sold in Exchanges and Subject to Essential Benefit Requirements

The Affordable Care Act places certain restrictions on the extent to which essential benefits can result in abortion coverage for individual and group plans sold in exchanges.[41]

Implementation

Agency

The newly established Office of Consumer Information and Insurance Oversight (OCIIO) within the Department of Health and Human Services will implement provisions relating to the essential benefits package.

Key Dates

Health plans subject to essential benefit requirements, which include small group

and individual plans that are not operating under "grandfather status," must comply beginning in plan years after January 1, 2014.

Process

The ACA requires the Secretary of HHS to use informal notice and comment rulemaking under Section 1302(c)(b)(3), which relates solely to defining essential benefits and periodically updating essential benefits. For other provisions, HHS has the discretion to use a range of tools to implement the statute, such as publishing regulations in the Federal Register with a public notice and comment period, or using other types of approaches such as posted policy instructions, funding availability announcements (where applicable), official letters to affected entities (such as letters to state Medicaid agencies), and posted rulings and notices. Agency websites can be checked regularly for updates.

Key Issues

• *Health plans subject to essential benefit requirements*. The law specifies that all health plans sold in the individual and small group markets, whether or not it is sold in the exchange, will be subject to essential benefit. OCIIO regulations can be expected to address both the non-exchange market as well as the exchange market, delineating which requirements are applicable to qualified health plans sold in state health insurance exchanges and which requirements would apply to all individual and small group health plans sold in a state, regardless of whether the plan is sold through an exchange.
• *Level of detail in essential benefit development*: How detailed will the Secretary's definition be and how much latitude will be provided to insurers? Will the Secretary set standards that address benefit definitions, identify allowable limitations and exclusions, provide a medical necessity standard, include a non-discrimination definition and standard, or will the Secretary vest broad discretion in insurers to define covered treatments, procedures and providers within the essential benefit classes?
• *State mandated benefits*: How will the regulations address state benefit mandates? In the case of mandates applied to qualified health plans sold in state exchanges, a state would be expected to cover the additional incremental premium cost. In the case of state benefit mandates that are applied to health plans sold in the individual and small group markets outside the exchange, presumably the cost of the

mandates would be included in purchasers' premiums. If a state benefit mandates falls within an essential benefit class (for example, were a state law to mandate certain types of prescription drug treatments as part of the federal prescription drug essential benefit class) will federal essential benefit rules allow the plan to charge more for the coverage? How will the Secretary address the fact that many state benefit mandates are in fact specified treatments and procedures that fall within the established federal classes? If the state mandate is subsumed by a federal benefit class, will a state be required to pay an increment and will an insurer be permitted to charge more?

• *Balancing non-discrimination with directive that the essential benefit package meet standard of typical employer plan*: How will the Secretary interpret the non-discrimination provisions in light of the requirement to build the essential benefit package to parallel a typical employer plan? The law's non-discrimination provisions directly address discrimination against persons based on disability or expected length of life. Employer-sponsored plans frequently contain certain types of limitations and exclusions that lessen the value of coverage for persons with disabilities, such as the use of a "recovery" standard that withholds coverage from individuals who may not recover from a condition but may need treatment to maintain functioning or to avert the loss of functioning. How will the Secretary reconcile this requirement against an employer plan?

• *Survey of Employers*: How will the Secretary of HHS (for the purpose of defining scope of benefits) and the Secretary of Labor (for the purpose of surveying) define a "typical employer plan," and what affect will that definition have on benefits and cost of the essential benefit package? In defining benefits and periodically updating essential benefits, the Secretary must ensure that the scope of benefits is equal to the scope of benefits provided under a typical employer and multiple employer plans, as defined by the Secretary, and informed by a survey conducted by the Department of Labor. The American Academy of Actuaries has indicated that because health spending patterns differ across populations, it is important to use a representative population when performing actuarial equivalence calculations.[42] Employer plans vary widely from small group plans with significant limits on scope of benefit to more generous plans offered in the large group market, including those with older and sicker active and retired employees.

• *Defining benefit design versus utilization management*: The Act prohibits discrimination in benefit design but prohibits the Secretary

from barring the use of existing utilization management practices. How will the Secretary define what is benefit design versus utilization management, particularly the use of treatment guidelines to set coverage?

• *Benefit design and anti-discrimination*. The Secretary is prohibited from defining an essential benefits package that discriminates against individuals based on age, disability or life expectancy. How will the Secretary assure that this requirement applies to plans with respect to the following issues: benefit and coverage definitions; coverage limitations and exclusions; incentive programs; utilization management practices that can affect individuals with disabilities, particularly the use of treatment guidelines that do not consider co-occurring conditions?

Agency and Related Action

HHS has not released information relating to the definition of essential benefits. However, related information related to which plans will be required to meet essential benefit requirements were included in regulations relating to health insurance market reforms and grandfathered health insurance plans. An interim final rule took effect on June 12, 2010, and the Secretary issued five additional guidance documents from September through December, and amendments to the interim final rule on November 17.

Authorized Funding Levels

Provisions of the ACA relating to essential benefits are regulatory in nature and therefore are not subject to annual appropriations for funding, and do not involve the awarding of federal funds.

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[1] 29 U.S.C. 1185a.
[2] Id.
[3] 29 C.F.R. §2590.712(a).
[4] 42 C.F.R. §146.135(c)(4).
[5] 29 U.S.C. 1135, 1181, 1194.
[6] 29 U.S.C 1185b.
[7] P.L. 104-191.
[8] Allison Frey, Stephanie Mika, Rachel Nuzum, and Cathy Schoen, "Setting a National Minimum Standard for Health Benefits: How Do State Benefit Mandates Compare with Benefits in Large-Group Plans?" Commonwealth Fund Issue Brief 3

(June 2009).
[9] Victoria C. Bunce and JP Wieske, "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance. Available online at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf . (Accessed November 17, 2010).
[10] Nicole M. Bellows, Helen Ann Halpin, and Sara B. McMenamin, "State-Mandated Benefit Review Laws," Health Research and Educational Trust, June 2006.
[11] For a comprehensive discussion of discrimination in health insurance see Sara Rosenbaum, "Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law and Federal Reform Options," Legal Solutions in Health Reform, Georgetown University and the O'Neill Institute for National and Global Health Law.
[12] 42 U.S.C. §12102 et seq.
[13] 29 U.S.C §794.
[14] Rosenbaum at 9.
[15] S. Rosenbaum at 157-158.
[16] G. Claxton et al, "Health Benefits in 2010: Premiums Rise Modestly, Workers Pay More Toward Coverage," Health Affairs, published online September 2, 2010. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.2010.0725v1. Accessed November 23, 2010.
[17] Lurie et al, "Preventive Care: Do We Practice What We Preach," American Journal of Public Health, vol. 7, no. 7. (1987).
[18] G. Solanki and H.H. Schauffler, "Cost-Sharing and the Utilization of Clinical Preventive Services," American Journal of Preventive Services Volume 17, Issue 2 (August 1999).
[19] J. May and P. Cunningham, "Tough Trade-offs: Medical Bills, Family Finances and Access to Care," Center for Studying Health System Change. Issue Brief No. 85. June 2004.
[20] A. Mark Fendrick et al., Applying Value-Based Insurance Design to Low-Value Health Services, Health Affairs 29:11 pp. 217-221 (Nov., 2010).
[21] Report to accompany the "America's Healthy Future Act of 2009," Committee on Finance, United States Senate. December 18, 2009, p.4.
[22] Patient Protection and Affordable Care Act (PPACA) §1301(a).
[23] §1301 adding Public Health Service Act §2707.
[24] §1304(b)(2).
[25] §1304(b)(3).
[26] §1563.
[27] §1302(b).
[28] §1302(b)(2).
[29] §1302(b)(4).

[30] §1302(b)(5).
[31] §1311(d)(3)(B).
[32] §1565(d).
[33] §1302(c)(3).
[34] §1302(d).
[35] §1302(d)(1)(A).
[36] §1302(d)(1)(B).
[37] §1302(d)(1)(C).
[38] §1302(d)(1)(D).
[39] §1302(d)(2).
[40] §1302(e).
[41] See the Abortion Coverage Implementation Brief for more detailed information at http://healthreformgps.org/resources/abortion-coverage/.
[42] "Critical Issues in Health Reform: Actuarial Equivalence," May 2009. Available online at: http://www.actuary.org/pdf/health/equivalence_may09.pdf. Accessed November 23, 2010.

29 U.S.C. 1185a.Id.29 C.F.R. §2590.712(a).42 C.F.R. §146.135(c)(4).29 U.S.C. 1135, 1181, 1194.29 U.S.C 1185b.P.L. 104-191.Allison Frey, Stephanie Mika, Rachel Nuzum, and Cathy Schoen, "Setting a National Minimum Standard for Health Benefits: How Do State Benefit Mandates Compare with Benefits in Large-Group Plans?" Commonwealth Fund Issue Brief 3 (June 2009).Victoria C. Bunce and JP Wieske, "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance. Available online at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf . (Accessed November 17, 2010).Nicole M. Bellows, Helen Ann Halpin, and Sara B. McMenamin, "State-Mandated Benefit Review Laws," Health Research and Educational Trust, June 2006.For a comprehensive discussion of discrimination in health insurance see Sara Rosenbaum, "Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law and Federal Reform Options," Legal Solutions in Health Reform, Georgetown University and the O'Neill Institute for National and Global Health Law. 42 U.S.C. §12102 et seq.29 U.S.C §794.Rosenbaum at 9. S. Rosenbaum at 157-158.G. Claxton et al, "Health Benefits in 2010: Premiums Rise Modestly, Workers Pay More Toward Coverage," Health Affairs, published online September 2, 2010. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.2010.0725v1. Accessed November 23, 2010.Lurie et al, "Preventive Care: Do We Practice What We Preach," American Journal of Public Health, vol. 7, no. 7. (1987).G. Solanki and H.H. Schauffler, "Cost-Sharing and the Utilization of Clinical Preventive Services," American Journal of Preventive Services Volume 17, Issue 2 (August 1999).J. May

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