ESSENTIAL HEALTH BENEFITS FACT SHEET

INFORMED ON REFORM

Overview

The Patient Protection and Affordable Care Act (PPACA) requires a core package of health care services, known as essential health benefits (EHBs), in all non-grandfathered, insured health plans offered in the individual and small group markets, both inside and outside of the public exchanges.

There are federal health insurance standards related to EHBs, which are fully defined at the state level. Individual and small group health plans are required to offer the same EHBs with the intention to enhance consumers' ability to compare and make informed choices about health plan purchases.

Q Who must cover EHBs?

A Since January 1, 2014 all non-grandfathered, insured plans in the individual and small group markets – on and off the public exchange/Health Insurance Marketplace – are required to provide EHBs.

No other plans are required to provide EHBs. However, if they cover any benefits defined as EHBs, they cannot impose any annual or lifetime limits on the dollar value of those benefits.

PLAN/FUNDING TYPE	GRANDFATHER (GF) STATUS	MUST COVER EHBs	ANNUAL OR LIFETIME DOLLAR LIMITS ON EHBs PERMITTED
Individual and Insured Small Group	Non-GF	Yes	No
	GF	No	No
Insured Large Group	Non-GF	No	No
	GF	No	No
ASO Small Group and Large Group	Non-GF	No	No
	GF	No	No

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Q What are the EHBs?

A

In addition to the standard 10 EHB categories listed below, states may include additional benefit requirements under their own state regulations or within a state's selected benchmark plan.

- Ambulatory patient services
- Emergency services
- Hospitalization
- Mental health and substance use disorders/behavioral health treatment
- Maternity and newborn care
- Prescription drugs
- Rehabilitative and habilitative services/devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

Q What do employers need to do?

A

EHBs have the potential to increase the cost of the policies offered if the coverage is defined too comprehensively. Balancing comprehensive coverage and affordability is the ongoing debate and discussion for employers and insurers.

Self-insured plans need to consider their respective state benchmark plans, because any benefits in their plans defined by the state as EHBs cannot have annual or lifetime limits on the dollar value of those benefits. Effective on or after January 1, 2017, for *any plan* that covers an EHB service *both* in-network and out-of-network, the annual/lifetime dollar limits are prohibited on that EHB service *both* in-network and out-of-network. EHBs and their impacts on plans vary from state to state.

Q What impact do EHBs have on consumers?

A

EHBs help consumers in the individual and insured small group market shop for and compare health insurance options by:

- Promoting consistency across plans
- Protecting consumers by ensuring that all plans cover a core package of benefits that are equal in scope to benefits offered by a typical employer plan
- Limiting consumers' out-of-pocket expenses

Q How have states been involved?

A

States are required to fully define EHBs by selecting an existing health plan as a benchmark of services and items included in that state's EHB package. In this selection process, states choose one of four existing health insurance plans to be the benchmark for policies sitused in the state.

1. The largest plan, based on enrollment in any of the three largest small group products in the state (the default plan should a state not choose a benchmark plan)
2. Any of the three largest state employee health plans
3. Any one of the three largest federal employee health plan options
4. The largest HMO plan offered in the state's commercial market

The Department of Health and Human Services (HHS) determines the year of existing plans for which state benchmark plans will be selected, and when these benchmark plans will take effect. Plans available in 2010 were used for selecting benchmark plans effective 2014 through 2016. Plans available in 2014 were used for selecting benchmark plans effective beginning in 2017.

For plan years beginning on and after January 1, 2020, states have greater flexibility in selecting their benchmark plans. States may follow current rules listed above and maintain 2017 benchmark plans, or they may select a new EHB benchmark plan annually from one of the following three options:

- Choose another state's 2017 benchmark plan – allows states to select another state's 2017 benchmark plan, and implement the plan benefits and limits to their own EHB standards, such as changing benefits with dollar limits to non-dollar limits.
- Replace one or more of the 10 required EHB categories of benefits under its current 2017 benchmark plan with the same categories from another state's 2017 benchmark plan – giving states the ability to make precise changes to their 2017 benchmark plans at the coverage detail level. For example, State A may select the prescription drug coverage EHB from State B, which uses a different drug formulary.
- Otherwise select a new set of benefits to become its benchmark plan – provided the plan meets other specified requirements.

The three options are subject to additional requirements, including two scope of benefits conditions. States must affirm that their new/modified benchmark plan provides a scope of benefits that is equal to, or greater than, the scope of benefits provided under a "typical employer plan," and is no more generous than the most generous of a set of comparison plans.

State-mandated benefits

State mandates regarding provider types, cost-sharing or reimbursement methods are not considered EHBs. However, cost-sharing required by a state mandate applies only to the market specified in the mandate.

Please see our Cost-Sharing Fact Sheet for more information:
www.cigna.com/health-care-reform/cost-sharing-fact-sheet

Q What are excepted benefits?

A Excepted benefits are not subject to PPACA requirements, such as the limitations on out-of-pocket (OOP) expenses. The following explains how to determine whether dental or vision benefits are excepted benefits.

For insured plans

- Dental and vision benefits offered under a **separate** insurance policy from the medical coverage **are** excepted benefits.
- Dental and vision benefits that are **incorporated into** an insured medical plan **are not** excepted benefits.

For self-funded plans

- Dental and vision benefits **are** excepted benefits if they are offered under a **separate** plan from the medical insurance policy.
- Also, dental or vision benefits **are** excepted if the individual can elect or reject these benefits separately from medical benefits.
- Dental and vision benefits that are **incorporated** into the self-funded plan **are not** excepted benefits if employees enrolling in a medical plan automatically get the vision/dental benefits.

Q Are there any EHB requirements that should be specifically considered?

A Employers should take the following topics into consideration.

SERVICE	DETAILS
What it is/fee duration	Insurers are permitted to offer elective abortion services, but states can choose to prohibit or require these services under state law. Elective abortion services are not considered EHB even if covered by the benchmark plan.
Mental Health and Substance Use Disorder (MHSUD)	Non-Grandfathered individual and small group markets must cover MHSUD in accordance with parity standards based on the federal Mental Health Parity and Addiction Equity Act (MHPAEA).
Prescription drugs	• Prescription drugs are not required to be covered on a particular tier. HHS will study and take into consideration the effects of this policy. • Plans must cover at least the greater of: – One drug in every United States Pharmacopeia (USP) category and class; or – The same number of drugs in each category and class as in the EHB benchmark plan.
Pediatric	For purposes of pediatric dental and vision coverage, "pediatric" is defined as persons until at least the end of the month in which they turn age 19 (effective 1/1/2016), unless a state extends the definition.
Pediatric stand-alone dental services	Plans offered in the individual and insured small group market must either include pediatric dental benefits, or follow these rules for the provision of pediatric dental benefits as a stand-alone dental plan. **Stand-alone dental:** • Inside the Exchanges/Health Insurance Marketplaces – If a stand-alone pediatric dental option is available from any carrier on the Exchange, pediatric dental coverage can be excluded from the EHB package provided by the medical plan. – There is no requirement for an individual or family (with a child or without) to purchase a stand-alone plan if the Exchange medical plan does not cover the pediatric dental. • Outside the Exchanges/Health Insurance Marketplaces – Pediatric dental coverage can be excluded if carriers are reasonably assured that the individual has obtained pediatric dental coverage by an Exchange-certified stand-alone dental plan. It does not have to be purchased through an Exchange. – An individual or family must be offered coverage of all 10 categories of EHBs, either through one policy, or through a combination of a medical policy and an Exchange-certified stand-alone dental plan. • The definition of pediatric dental services is based on either the FEDVIP plan, or the state's CHIP plan, depending on which plan the state selected. In some states, the benchmark plan includes pediatric dental services. Under these plans, pediatric dental services are often broader than screenings, and include dental checkups. By maintaining excepted benefit status, dental benefits are exempt from most PPACA and HIPAA requirements that are applicable to medical plans.
Pediatric vision	Plans offered in the non-grandfathered individual and insured small group markets must cover pediatric vision services. The definition of pediatric vision services is based on whichever plan the state selected, either the FEDVIP vision plan, or the state's CHIP plan with the largest enrollment. Under both plans, vision services are broader than screenings, and include vision exams, eyeglasses and other materials.

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