

ESSENTIAL HEALTH BENEFITS FACT SHEET

This fact sheet reflects the final rule of Standards Related to Essential Health Benefits published by the Department of Health and Human Services on February 20, 2013, and includes updated excepted benefits rules communicated December 24, 2013.

Overview

The Affordable Care Act requires that non-grandfathered, insured health plans offered in the individual and small group markets, both inside and outside of the Exchanges, provide a core package of health care services, known as “essential health benefits” (EHB).

This rule outlines health insurance standards related to the coverage of EHBs. It also provides flexibility to allow states to shape how EHBs are defined. Since insurers in the individual and small group markets are required to offer the same EHBs, the intent is to enhance consumers’ ability to compare and make informed choices about health plan purchases.

Q: WHO MUST COVER ESSENTIAL HEALTH BENEFITS?

A: All non-grandfathered, insured plans in the individual and small group markets – on and off the Exchange/Health Insurance Marketplace – are required to provide EHBs, with the start of plan years that begin on or after January 1, 2014 (policy years in the case of individual policies).

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 Status	Must Cover Essential Health Benefits	Defines EHB	Annual Or Lifetime \$ Limits On EHB Permitted
Individual and Insured Small Group	Non-GF	Yes	State	No
	GF	No	State	No
Insured Large Group	Non-GF	No	State	No
	GF	No	State	No
ASO Small Group and Large Group	Non-GF	No	Employer	No
	GF	No	Employer	No

Q: WHAT ARE THE ESSENTIAL HEALTH BENEFITS?

A: Essential Health Benefits will include the following 10 general categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Mental health and substance abuse 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 IMPACT WILL EHBS HAVE ON CONSUMERS?

A: EHBS will 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 items that are equal in scope to benefits offered by a typical employer plan
- Limiting consumers' out-of-pocket expenses

Q: WHAT WILL STATES NEED TO DO?

A: The regulations require that states define EHBS for policies situated in the state. To meet this requirement, each state selected an existing health plan as a "benchmark" to establish services and items included in that state's EHB package.

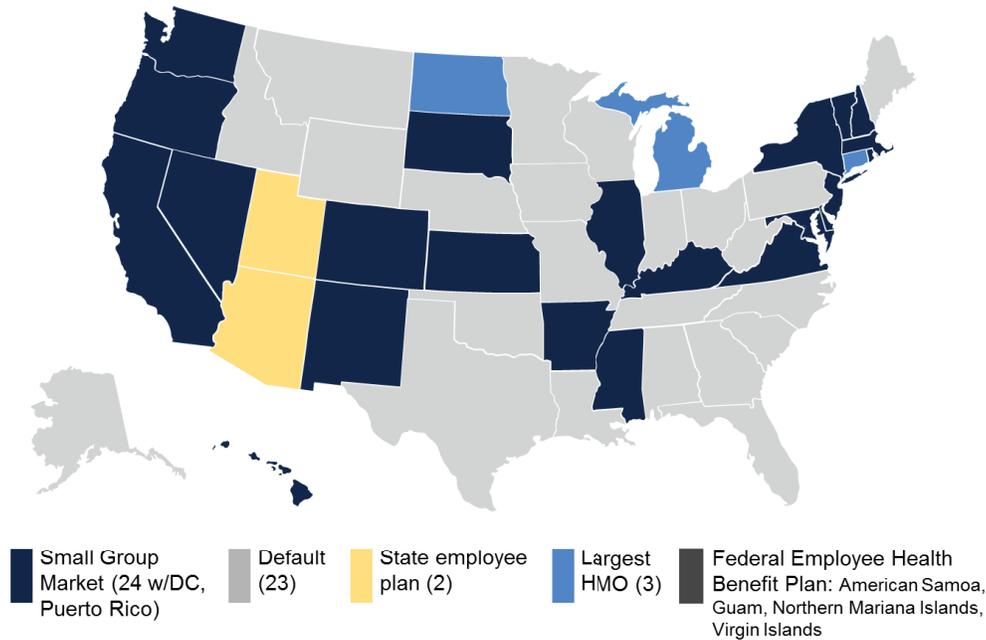
Per Department of Health and Human Services (HHS) guidance, states were required to choose from one of four health insurance plan options as a benchmark:

- The largest plan, based on enrollment in any of the three largest small group products in the state
- Any of the three largest state employee health plans
- Any one of the three largest federal employee health plan options
- The largest HMO plan offered in the state's commercial market

The selected benchmark plans are finalized for benefit years 2014 and 2015. If a state did not choose a benchmark plan, the largest small group plan in the state automatically became the benchmark (the "default").

The map below reflects the Centers for Medicare and Medicaid Services (CMS) summary of the benchmark plan selections and defaults provided on 3/8/2013.

ESSENTIAL HEALTH BENEFITS - MEDICAL State Benchmark Plan Status

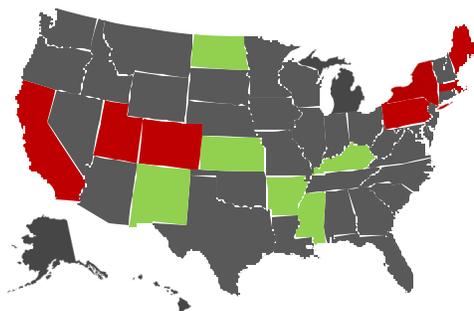


Source: CCIIO, 3/8/2013

If a benchmark plan did not include pediatric dental/vision coverage, states were able to select from either the Federal Employees Dental and Vision Insurance Program (FEDVIP) or State Children's Health Insurance Plan (CHIP) plans to ensure comprehensive EHB coverage.

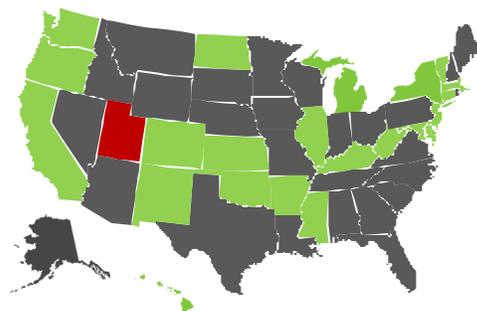
If the benchmark plan does not include habilitative services, states can define covered services, or provide a broad definition encompassing a variety of services/items that the plan must cover. If the state does not define habilitative, then the carriers will define.

TRENDS OF SELECTED SUPPLEMENTAL PLANS



Pediatric Vision trends:

- 70% selected the Federal Pediatric Vision Plan
- Six states elected the supplemental plan outlined in their CHIP
- Seven states included supplemental vision in their Benchmark plans
- U.S. Territories have the Federal Employee Dental/Vision Plan



Pediatric Dental trends:

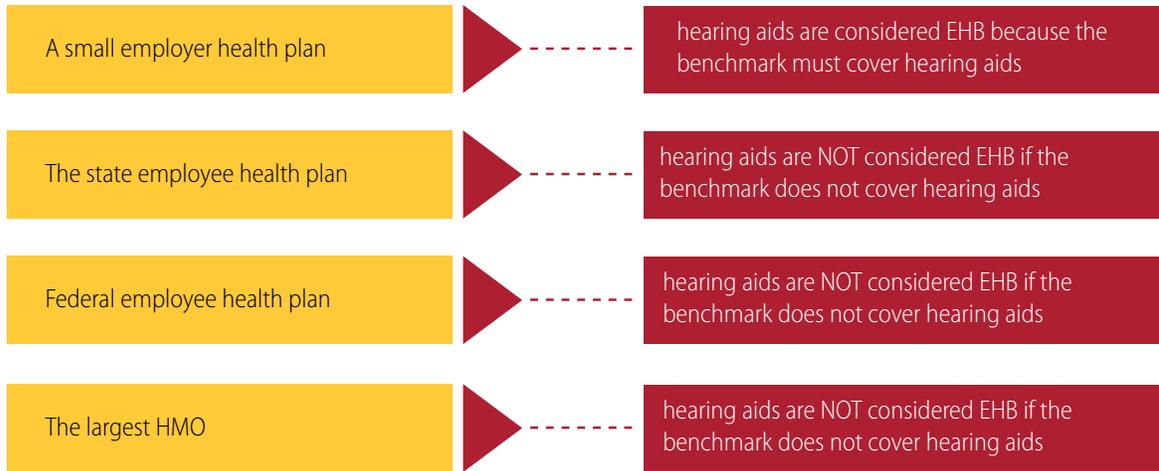
- 52% selected the Federal Pediatric Dental Plan
- 46% elected the supplemental dental plan outlined in their CHIP
- One state included supplemental dental in its Benchmark plan - Utah

State-mandated benefits

State-mandated benefits included in the benchmark plan are considered EHB for plans offered in the individual and non-grandfathered insured small group markets on and off the Exchange health insurance marketplace.

State benefit mandates that are not included in the benchmark plan still apply, where applicable, under the state law.

For example, **if** a state mandates that hearing aids must be covered by small group insured plans, and the state benchmark is:



State mandates regarding provider types, cost sharing or reimbursement methods do not pertain to EHB.

However, cost-sharing required by the mandate only applies to the specific market the mandate applies to. Please see our Cost-Sharing Fact Sheet for more information.

Q: WHAT DO EMPLOYERS NEED TO DO?

A: EHB has 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.

Self-insured plans will also need to watch this development, because if their plans include any of the essential health benefits, they cannot impose annual or lifetime limits on the dollar value of EHBs. Also, the impact will likely vary from state to state.

Q: WHAT DO EMPLOYERS NEED TO KNOW?

A: Additional details from the final rule:

Service	Details
Abortion services	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 Abuse (MHSA)	Individual and small group markets must cover MHSA in accordance with parity standards based on the federal Mental Health Parity and Addiction Equity Act (MHPAEA).
Prescription drugs	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – One drug in every United States Pharmacopeia (USP) category and class; or – The same number of drugs in the EHB benchmark plan
Pediatric	“Pediatric” is defined as under the age of 19, unless a state extends the definition.
Pediatric stand-alone dental services	<p>Beginning 1/1/14, the definition of pediatric dental services will typically be based on either the FedVIP plan, or the State 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. 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:</p> <p>Stand-alone Dental:</p> <ul style="list-style-type: none"> • Inside the Exchanges/Health Insurance Marketplaces <ul style="list-style-type: none"> • If a stand-alone pediatric dental option is available from any carrier on the Exchange, from any carrier, 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 <ul style="list-style-type: none"> • 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 ten categories of EHBs, either through one policy, or through a combination of a medical policy and an Exchange-certified stand-alone dental plan. <p>Self-funded and large group plans do not have to offer the pediatric dental benefit. Only plans that are “excepted benefits” can impose annual or lifetime dollar limits for pediatric dental EHBs for anyone under 19.</p> <ul style="list-style-type: none"> • By maintaining excepted benefit status, dental benefits are exempt from PPACA and HIPAA requirements that are applicable to medical plans.
Pediatric Vision	<p>Plans offered in the non-grandfathered individual and non-grandfathered insured small group market must cover pediatric vision services. Beginning 1/1/14, the definition of pediatric vision services will typically be based on either the FedVIP plan, or the State CHIP plan, depending on which plan the state selected. Under both plans, vision services are broader than screenings, and include vision exams, eyeglasses and other materials.</p> <p>Self-funded and large group plans do not have to cover the pediatric vision benefit. However, if they have a vision plan that is not an “excepted benefit,” annual & lifetime dollar limits are banned for persons under 19 on the services deemed pediatric vision EHBs (e.g., yearly vision exams).</p>

“Excepted benefits” explained

Insured plans

- Dental and vision benefits offered under an insurance policy that is **separate** from other medical coverage are “excepted benefits” and **not** subject to PPACA health insurance reform provisions such as the Essential Health Benefits (EHB) mandate.
- Dental and vision benefits that are **incorporated into** the insured medical plan are not “excepted benefits” and therefore **are** subject to the PPACA EHB requirement.

Self-funded plans

- Dental and vision benefits offered under a plan that is **separate** from the medical coverage **are** excepted benefits if the individual can separately elect or reject the dental or vision benefits.
- Dental and vision benefits are **not** “excepted benefits” if employees enrolling in medical automatically get the vision/dental benefits.



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