

# National Indian Health Board

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## Analysis of the Essential Health Benefits Informational Bulletin Issued by HHS on December 16, 2011

### Summary of Agency Action

As a component of implementing section 1302 of the Affordable Care Act,<sup>1</sup> the following introduction was published in an HHS Informational Bulletin: Essential Health Benefits –

*On December 16, 2011, the Department of Health and Human Services issued a bulletin outlining proposed policies that will give States more flexibility and freedom to implement the Affordable Care Act. This bulletin describes a comprehensive, affordable and flexible proposal and informs the public about the approach that HHS intends to pursue in rulemaking to define essential health benefits.*

*HHS is releasing this intended approach to give consumers, states, employers and issuers timely information as they work towards establishing Affordable Insurance Exchanges and making decisions for 2014. This approach was developed with significant input from the American people, as well as reports from the Department of Labor, the Institute of Medicine, and research conducted by HHS.*

Comments on the proposal may be submitted to the Department of Health and Human Services (HHS) through January 31, 2012.

### What Does the ACA require regarding the Essential Health Benefits Package?

Under section 1302(b) of the Affordable Care Act, the Secretary of HHS is to define the essential health benefits (EHB) package. The EHB package is to include at least the ten categories of coverage listed in the ACA.<sup>2</sup> In general, the Secretary is to

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<sup>1</sup> Refers collectively to the Patient Protection and Affordable Care Act (Pub.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. Section 36B, contained in section 1401 of the ACA, was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).

<sup>2</sup> Section 1302(b)(1) requires the following categories of services to be included: (A) Ambulatory patient services; (B) Emergency services; (C) Hospitalization; (D) Maternity and newborn care; (E) Mental health and





ensure that the scope of the EHB package “is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.” (§1302(b)(2)(A)) In defining the EHB package, and in revising the EHB package, the Secretary is to provide notice and an opportunity for public comment.

In August of 2011, CMS issued a proposed template for the Summary of Benefits and Coverage, as well as a Uniform Glossary, which is to be used by health plans to accurately describe the benefits and coverage under the applicable plan or coverage.<sup>3</sup>

On December 16, 2011, HHS issued an informational bulletin on Essential Health Benefits.<sup>4</sup> This NIHB analysis reviews the HHS informational bulletin on EHB.

### What is HHS Proposing in the Informational Bulletin on EHB?

As indicated in the Bulletin, HHS indicated that it intends to propose that essential health benefits be defined using a “benchmark” approach. This approach is in contrast to what was initially expected from HHS, which was a specific federal articulation and elaboration on the 10 categories of coverage contained in the ACA.

The HHS proposal is to give each state the ability to choose—from a set of options identified by HHS—the particular EHB package that will apply in their state. Under the HHS proposal, states will choose one of the following benchmark health insurance plans as their EHB package:

- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment;
- The largest HMO plan offered in the state’s commercial market by enrollment.

The benefit package selected by the State would be “modified as necessary to reflect the 10 coverage categories.” If a state chooses not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state.

Health plans would be required to offer benefits that are “substantially equal” to the benchmark plan selected by the state.<sup>5</sup> However, under the section header “Allowing

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substance use disorder services, including behavioral health treatment; (F) Prescription drugs; (G) Rehabilitative and habilitative services and devices; (H) Laboratory services; (I) Preventive and wellness services and chronic disease Management; and (J) Pediatric services, including oral and vision care.

<sup>3</sup> Federal Register, Vol. 76, No. 162, Monday, August 22, 2011, page 52475, CMS-9982-P: Summary of Benefits and Coverage and the Uniform Glossary.

<sup>4</sup> <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

<sup>5</sup> HHS Informational Bulletin: Essential Health Benefits, December 16, 2011.

<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>



Plans Flexibility to Innovate and Consumers Greater Choice”, it is stated that “[h]ealth plans also would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided they continue to offer coverage for all 10 statutory EHB categories and the coverage has the same value.”<sup>6</sup> Because the services covered and the quantitative limits on these services could be adjusted, in effect, the requirement that “the coverage has the same value” would be the primary standard being established by the State selecting a benchmark plan. The “value” of the benefit package (i.e., actuarial value, or average cost of the benchmark plan for a defined enrollee population) offered by a plan would need to match the value of the State-selected benchmark benefit package, but the specific services covered and any limitations on the number of the services covered could vary by health plan. The “value” of the benefit package chosen by the State would be higher or lower depending which of the benchmark plan options were chosen.

At this time, HHS is not proposing a set of regulations. The HHS informational bulletin was issued to provide guidance to the public, and especially to states that are preparing to operate Affordable Health Insurance Exchanges (Exchanges), as early as possible. The informational bulletin does not have the force of law. It is anticipated that HHS will issue a regulation on the EHB at a future (but unspecified) date. In addition, it is anticipated that HHS will issue regulations on other aspects of coverage, including deductibles and co-payments, as well as actuarial value and levels of coverage. Through the informational bulletin, HHS is providing notice that it intends to allow states to select (i.e., define) the particular EHB for their state. In addition, and as required by the ACA, the bulletin gives an opportunity for public comment on the Secretary’s proposal, with comments to be filed through [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov) by January 31, 2012.

#### Issues / Ramifications of the HHS Approach on EHB

- HHS-centered deliberations on the EHB package will be largely side-stepped by HHS as it delegates the definition of the EHB package to the states.
- For the federally-operated Exchanges, as well as for states in which the state has not selected an EHB, HHS indicated that it intends to select “the small group plan with the largest enrollment in the state.”
- The EHB package for the multi-state plans (authorized under § 1334 of the ACA) that is offered in each Exchange may be different from the EHB package used by other plans in an Exchange. (See ACA § 1334(c)(1)(A).)
- The “benchmark” approach proposed by HHS for the EHB package is similar to the provision in the ACA establishing the benefits package under the Medicaid

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<sup>6</sup> HHS Informational Bulletin.



expansion.<sup>7</sup> For individuals covered under the new Medicaid eligibility category, they will receive “benchmark” or “benchmark-equivalent” coverage consistent with the requirements of section 1937 of the Social Security Act. Under section 1937, each state is to select the benchmark coverage that provides at least the EHB as described in § 1302(b) of the ACA, such as the benefit package under the standard Blue Cross/Blue Shield preferred provider option under the Federal Health Benefits Program or the benefit package offered to state employees.

- The HHS proposal does not directly address the issue of the benefit package to be offered under the Medicaid expansion. But by deferring to States on the EHB package to be offered through an Exchange, a similar approach may be taken (or is being taken) by HHS with regard to the benefit package under the Medicaid expansion. As such, States might use the same benefit package for the Medicaid expansion as is being proposed for the Exchange. Under these “benchmark” approaches that tie to benefit packages offered in the private market, some of the traditional “wrap-around” services that Medicaid recipients currently receive (such as transportation) would not be covered.
- The ACA prohibited federal funds (in the form of premium subsidies) from being used to cover the cost of state benefit mandates that are in excess of the federally-defined EHB package. But by including health benefit packages that are designed pursuant to state law as an option for the “benchmark” EHB package, state-specific benefit mandates could be included in a state’s EHB package, and as such, the federal premium subsidies would cover these state-mandated services. HHS is directed to periodically update the EHB package, and HHS indicated that “state mandates outside the definition of essential health benefits may not be included in future years.”

### Next Steps

Comments may be submitted to HHS on the Essential Health Benefits: HHS Informational Bulletin. All comments are to be submitted to [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov) prior to January 31, 2012.

### Resources

- For the HHS essential health benefits bulletin:  
<http://cciio.cms.gov/resources/regulations/index.html#hie>

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<sup>7</sup> See NIHB Issue Paper, “Medicaid Expansion under ACA for American Indians and Alaska Natives”.



- For the HHS fact sheet on the essential health benefits bulletin:  
<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>
- For a summary of individual market coverage as it relates to essential health benefits: <http://aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.shtml>
- For information comparing benefits in small group products and state and Federal employee plans:  
<http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml>
- To read the entire HHS Press Release issued on 12/19/11:  
<http://www.hhs.gov/news/press/2011pres/12/20111216b.html>
- To read the Institute of Medicine report, “Essential Health Benefits: Balancing Benefits and Cost”:  
<http://www.iom.edu/~media/Files/Report%20Files/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost/essentialhealthbenefitsreportbrief4.pdf>
- To access Institute of Medicine Website on Essential Health Benefits:  
<http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>