

Health Reform Update- November, 2011

Feds Give Authority to Define “Essential Health Benefits”

The U.S. Department of Health and Human Services (HHS) surprised advocates and state insurance regulators when it issued a [bulletin](#) 12/16/2011 giving states the authority to define their own Essential Health Benefit (EHB) package, which is the minimum coverage standards states will require for health plans sold through the new state Health Insurance Exchanges, as well as in the individual and small group markets, starting in 2014.

The federal reform law – the Affordable Care Act (ACA) – requires HHS to provide a uniform national EHB standard. The EHB provision in the ACA lists broad categories of services that must be covered and requires the Secretary of Health and Human Services (HHS) to define the EHB in detail. At the beginning of this process, several months ago, HHS asked the Institute of Medicine (IOM) to recommend a basic EHB. Attempting to balance comprehensiveness with affordability, the IOM recommended setting the national benchmark to a “typical” small employer plan and endorsed the following 10 categories of items and services that the national EHB should cover: 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.

It was expected that HHS would actually define that benefit package, eligible service by eligible service. Instead, the HHS bulletin tells states to set their own EHB standard by selecting one of the following existing plans in their state as the “benchmark” coverage option.

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

So, rather than adopt a nationally uniform EHB, the feds have, basically, handed off the decision to the states --- not just for how the Exchange operates, but for the minimum coverage all Exchange and small group/non-group market plans.

There’s another impact to this HHS decision on plan benefits in Vermont: while the ACA already allowed states to mandate benefits beyond the EHB, the law said that states must cover the additional costs of those mandates for all individuals enrolled in any plan offered through a state’s health benefits exchange. For states, such as Vermont, with numerous benefit mandates, that cost would be substantial. However, this new HHS guidance allows existing state mandates to be included in the state’s EHB in 2014 and 2015 with the federal government picking up the additional costs.

Thus, any of the plans Vermont chooses as its benchmark will include state mandates, and those mandates will not present an additional cost burden to the state in 2014 and 2015. This greatly reduces the pressure on the state to adopt a “slimmed down” plan for the Exchange to reduce state liabilities for subsidies. Now, for example, Vermont could designate something like the State Employee plan as the EHB level that plans would have to cover.

Because the Shumlin Administration has announced their intention to redefine “small group” market to cover employers up to 100 (it is currently <50), then this new EHB standard in Vermont would cover (by VT DOL figures) more than 95% of Vermont businesses.

The HHS decision affects only the health services and benefits that are covered by plans; the allowed deductibles, co-payments and co-insurance requirements are still to be ruled on by HHS in the coming months.

The HHS decision, and what Vermont ultimately adopts, will have an impact on plans sold in the Exchange, and all plans sold in small group and individual markets outside of the Exchange (to the extent that Vermont allows that market to continue). It would take a further amendment of Vermont’s insurance statutes to apply the EHB standard to the Large Group Market. Vermont is still prohibited by ERISA from imposing any EHB standard on self-insured plans.

Additional resources:

[Implementing Reform: Funding And Flexibility For States On Exchanges – Health Affairs Blog](#) Implementing Reform: Funding And Flexibility For States On Exchanges, Timothy Yost, *Health Affairs Blog*, 12/16/2011

[Essential Health Benefits: Balancing State Flexibility with Consumer Protections](#), Sara R. Collins, Commonwealth Fund Blog, 12/20/2011

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