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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Frequently Asked Questions on Essential Health Benefits Bulletin

On December 16, 2011, the Department of Health and Human Services (HHS) released a Bulletin[i] describing the approach it intends to take in future rulemaking to define the essential health benefits (EHB) under the Affordable Care Act. This document is intended to provide additional guidance on HHS's intended approach to defining EHB.

1. Under the approach described in the Bulletin, would the Secretary permit the State to adopt different benchmark plans for its individual and small group markets?

   A: No. A State would select only one of the benchmark options as the applicable EHB benchmark plan across its individual and small group markets both inside and outside of the Exchange. HHS believes that selecting one benchmark for these markets in a State would result in a more consistent and consumer-oriented set of options that would also serve to minimize administrative complexity. HHS seeks to provide flexibility to issuers by permitting actuarially equivalent substitution of benefits within the ten categories of benefits required by the Affordable Care Act.

2. When a State chooses an EHB benchmark plan, would the benefits be frozen in time, or as the benchmark plan updates benefits each year, would the benchmark plan reflect these updates?

   A: As indicated in the Bulletin, we intend to propose a process for updating EHB in future rulemaking. Under the intended approach, the specific set of benchmark benefits selected in 2012 would apply for plan years 2014 and 2015. For 2014 and 2015, the EHB benchmark plan selection would take place in the third quarter of 2012. A consistent set of benefits across these two years would limit market disruption during this transition period. As indicated in the Bulletin, HHS intends to revisit this approach for plan years starting in 2016.

3. Would States be required to defray the cost of any State-mandated benefit?

   A: The Affordable Care Act requires States to defray the costs of State-mandated benefits in qualified health plans (QHPs) that are in excess of the EHB. If a State were to choose a benchmark plan that does not include all State-mandated benefits, the Affordable Care Act would require the State to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark.

   States have several benchmark options from which to choose, including the largest small group market plan in the State, which is the default benchmark plan for each State. Generally, insured plans sold in the small group market must comply with State mandates to cover benefits. Thus, if a small group market benchmark plan was selected, these mandated benefits would be part of the State-selected EHB. However, if there are State mandates that do not apply to the small group market,

such as mandates that apply only to the individual market or to HMOs, the State would need to defray the costs of those mandates if the mandated benefits were not covered by the selected benchmark.

As indicated in the Bulletin, the treatment of State benefit mandates is intended as a two-year transitional policy that HHS intends to revisit for plan years starting in 2016.

4. Could a State add State-mandated benefits to the State-selected EHB benchmark plan today without having to defray the costs of those mandated benefits?

   A: No. We intend to clarify that under the proposed approach any State-mandated benefits enacted after December 31, 2011 could not be part of EHB for 2014 or 2015, unless already included within the benchmark plan regardless of the mandate. Note that any State-mandated benefits enacted by December 31, 2011 would be part of EHB if applicable to the State-selected EHB benchmark plan. As mentioned above, HHS intends to revisit this approach for plan years starting in 2016.

5. How must a State supplement a benchmark plan if it is missing coverage in one or more of the ten statutory categories?

   A: We intend to propose that if a benchmark plan is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category, as described in the Bulletin. For example, if a benchmark plan covers newborn care but not maternity services, the State must supplement the benchmark to ensure coverage for maternity services. The default benchmark plan would be supplemented by looking first to the second largest small group market benchmark plan, then to the third, and then, if neither of those alternative small group market benchmark plans offers benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment.

   Our research found that three categories of benefits - pediatric oral services, pediatric vision services, and habilitative services - are not included in many health insurance plans. Thus, the Bulletin describes special rules to ensure meaningful benefits in those categories:

   - **As a transitional approach for habilitative services, the Bulletin discusses two alternative options that we are considering proposing:**
     - **A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.**
     - **A plan would decide which habilitative services to cover and report the coverage to HHS. HHS would evaluate and further define habilitative services in the future. Under either approach, a plan would be required to offer at least some habilitative benefit.**
   - **For pediatric oral care, we are considering proposing that the State would supplement the benchmark plan with benefits from either:**

- **The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or**
- **The State's separate Children's Health Insurance Program (CHIP).**

- **For pediatric vision care, we are considering proposing that the State would supplement the benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment.**

6. One of the currently intended benchmark plans is *the largest plan by enrollment in any of the three largest products in the small group market.* What is the difference between a plan and a product?

   A: For the purpose of administering the health plan finder on HealthCare.gov, HHS has defined "health insurance product" (product) as a package of benefits an issuer offers that is reported to State regulators in an insurance filing. Generally, this filing describes a set of benefits and often a provider network, but does not describe the manner in which benefits may be tailored, such as through the addition of riders. For purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product excluding all riders. HHS intends to propose that if benefits in a statutory category are offered only through the purchase of riders in a benchmark plan, that required EHB category would need to be supplemented by reference to another benchmark as described in question 5.

7. What is the minimum set of benefits a plan must offer in a statutory category to be considered to offer coverage within the category consistent with the benchmark plan?

   A: Under the approach described in the Bulletin, a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR 457.431, and provided that substitutions would not violate other statutory provisions. For example, a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20 covered occupational therapy visits, assuming actuarial equivalence and the other criteria are met. The benchmark plan would provide States and issuers with a frame of reference for the EHB categories.

8. Can scope and duration limitations be included in the EHB?

   A: Yes. Under the intended approach, a plan must be substantially equal to the benchmark plan, in both the scope of benefits offered and any limitations on those benefits such as visit limits. However, any scope and duration limitations in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. In addition, the Public Health Service Act (PHS Act) section 2711, as added by the Affordable Care Act, prohibits imposing annual and lifetime dollar limits on EHB. Note that for annual dollar limits, the prohibition generally applies in full starting in 2014, with certain restricted annual limits permitted until that time. The prohibition on annual dollar limits does not apply to grandfathered individual market policies.

9. State-mandated benefits sometimes have dollar limits. How does the intended EHB policy interact with the annual and lifetime dollar limit provisions of the Affordable Care Act?

   A: PHS Act section 2711, as added by the Affordable Care Act, does not permit annual or lifetime dollar limits on EHB. Therefore, if a benefit, including a State-mandated benefit, included within a State-selected EHB benchmark plan was to have a dollar limit, that benefit would be incorporated into the EHB definition without the dollar limit.

   However, based on the Bulletin describing our intended approach, plans would be permitted to make actuarially equivalent substitutions within statutory categories. Therefore, plans would be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

10. How would the intended EHB policy affect self-insured group health plans, grandfathered group health plans, and the large group market health plans? How would employers sponsoring such plans determine which benefits are EHB when they offer coverage to employees residing in more than one State?

    A: Under the Affordable Care Act, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB. However, the prohibition in PHS Act section 2711 on imposing annual and lifetime dollar limits on EHB does apply to self-insured group health plans, large group market health plans, and grandfathered group market health plans. These plans are permitted to impose non-dollar limits, consistent with other guidance, on EHB as long as they comply with other applicable statutory provisions. In addition, these plans can continue to impose annual and lifetime dollar limits on benefits that do not fall within the definition of EHB.

    To determine which benefits are EHB for purposes of complying with PHS Act section 2711, the Departments of Labor, Treasury, and HHS will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB.

11. In the case of a non-grandfathered insured small group market plan that offers coverage to employees residing in more than one State, which State-selected EHB benchmark plan would apply?

    A: Generally, the current practice in the group health insurance market is for the health insurance policy to be issued where the employer's primary place of business is located. As such, the employer's health insurance policy must conform to the benefits required in the employer's State, given that the employer is the policyholder. Nothing in the Bulletin or our proposed approach seeks to change this

current practice. Therefore, the applicable EHB benchmark for the State in which the insurance policy is issued would determine the EHB for all participants, regardless of the employee's State of residence. Health insurance coverage not required to offer EHB, including grandfathered health plans and large group market coverage, would comply with the applicable annual and lifetime limits rule, as described in the answer to the previous question.

12. How do the requirements regarding coverage of certain preventive health services under section 2713 of the PHS Act interact with the intended EHB policy?

    A: The preventive services described in section 2713 of the PHS Act, as added by section 1001 of the Affordable Care Act, will be a part of EHB.

13. Under the intended EHB approach, would the parity requirements in MHPAEA be required in EHB?

    A: Yes. Consistent with Congressional intent, we intend to propose that the parity requirements apply in the context of EHB.

14. Could a State legislature require that issuers offer a unique set of "EHB" the way Medicaid and CHIP benchmarks have options for Secretary-approved benefits, or benchmark equivalent benefits, if the State benefits are actuarially equivalent to one of the choices that HHS defines to be EHB?

    A: No. Under the approach we intend to propose, States would be required to adhere to the guidelines for selecting a benchmark plan outlined in the Bulletin. Otherwise, EHB in that State would be defined by the default benchmark plan.

15. Would States need to identify the benchmark options themselves?

    A: HHS plans to report the top three FEHBP benchmark plans to States based on information from the Office of Personal Management. HHS also plans to provide States with a list of the top three small group market products in each State based on data from HealthCare.gov from the first quarter of the 2012 calendar year. We intend to continue working with States to reconcile discrepancies in small group market product enrollment data. If a State chooses to consider State employee plans and/or the largest commercial HMO benchmark plans, the State would be required to identify benchmark options for those benchmark plans, as is done today in Medicaid and CHIP.

16. When would States be required to select a benchmark plan?

    A: As noted in the Bulletin, we intend to propose that States must select an EHB benchmark plan in the third quarter two years prior to the coverage year, based on enrollment from the first quarter of that year. Thus, HHS anticipates that selection of the benchmark plan for 2014 and 2015 would need to take place in the third quarter of 2012 in order to provide each State's EHB package, which includes the benchmark plan, any State-supplemented benefits to ensure coverage in all statutory categories, and any adjustments to include coverage for applicable State

mandates enacted before December 31, 2011. This schedule would ensure plans have time to determine benefit offerings before QHP applications are due. Separate guidance on the selection of Medicaid benchmark plans is forthcoming.

17. How would a State officially designate and communicate its choice of benchmark plan and the corresponding benefits to HHS?

A: HHS is currently evaluating options for collecting a State's benchmark plan selection and benefit information. A State's EHB package would include the benefits offered in the benchmark plan, any supplemental benefits required to ensure coverage within all ten statutory categories of benefits, and any adjustments to include coverage for applicable State mandates enacted before December 31, 2011. HHS anticipates that submissions will be collected from States in a standardized format that includes the name of the benchmark plan along with benefit information and, if necessary, the benefits used to ensure coverage within a missing statutory category.

18. How can my State find benefit information with respect to the default benchmark plan?

A: As indicated in the Bulletin, we intend to propose that the default benchmark plan in each State would be the largest small group market product in the State's small group market. HHS anticipates that it will identify and provide benefit information with respect to State-specific default benchmark plans in the Fall of 2012.

19. By empowering the State to select an EHB benchmark plan, does HHS intend that the State executive branch (i.e., State Insurance Department) or the legislative branch must make the selection?

A: Each State would be permitted to select a benchmark plan from the options provided by HHS by whatever process and through whatever State entity is appropriate under State law. In general, we expect that the State executive branch would have the authority to select the benchmark plan. It is also possible that, in some States, legislation would be necessary for benchmark plan selection. It is important to note that, regardless of the entity making these State selections, it is the State Medicaid Agency that will be held responsible for the implementation of EHB through the Medicaid benchmark coverage option.

EHB Applicability to Medicaid:

20. How would EHB be defined for Medicaid benchmark or benchmark-equivalent plans?

A: Since 2006, State Medicaid programs have had the option to provide certain groups of Medicaid enrollees with an alternative benefit package known as "benchmark" or "benchmark-equivalent" coverage, based on one of three commercial insurance products, or a fourth, "Secretary-approved" coverage option. Beginning January 1, 2014, all Medicaid benchmark and benchmark equivalent plans must include at least the ten statutory categories of EHBs. Under the Affordable Care Act, the medical assistance provided to the expansion population of

adults who become eligible for Medicaid as of January 1, 2014, will be a benefit package consistent with section 1937[ii] benchmark authority.

For Medicaid benchmark and benchmark equivalent plans, three of the benchmark plans described in section 1937 (the State's largest non-Medicaid HMO, the State's employee health plan, and the FEHBP BCBS plan) may be designated by the Secretary as EHB benchmark plans, as described in the EHB Bulletin. A State Medicaid Agency could select any of these section 1937 benchmark plans as its EHB benchmark reference plan for Medicaid. There would be no default EHB benchmark reference plan for purposes of Medicaid; each State Medicaid Agency would be required to identify an EHB benchmark reference plan for purposes of Medicaid as part of its 2014-related Medicaid State Plan changes.

If the EHB benchmark plan selected for Medicaid were to lack coverage within one or more of the ten statutorily-required categories of benefits, the EHB benchmark plan (and therefore the section 1937 benchmark plan) would need to be supplemented to ensure that it provides coverage in each of the ten statutory benefit categories. This would be in addition to any other requirements for Section 1937 plan, including Mental Health Parity and Addition Equity Act compliance.

21. Could a State select a different EHB benchmark reference plan for its Medicaid section 1937 benchmark and benchmark equivalent plans than the EHB reference plan it selects for the individual and small group market?

    A: Yes. Under our intended proposal, a State would not be required to select the same EHB benchmark reference plan for Medicaid section 1937 plans that it selects for the individual and small group market, and it could have more than one EHB benchmark reference plan for Medicaid, for example, if the State were to develop more than one benefit plan under section 1937.

22. Could a State select its regular Medicaid benefit plan as its Section 1937 benchmark coverage package?

    A: Yes. A State could propose its traditional Medicaid benefit package as a section 1937 benchmark plan under the Secretary-approved option available under section 1937 of the Social Security Act. The State would have to ensure, either through that benefit plan or as a supplement to that plan, that the ten statutory categories of EHB are covered.

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[i] You can access the Bulletin at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

[ii] You can access section 1937 at http://www.ssa.gov/OP_Home/ssact/title19/1937.htm