Key Issues in Meeting Requirements of Essential Health Benefits

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SEC. 2707 COMPREHENSIVE HEALTH INSURANCE COVERAGE

(a) Coverage for Essential Health Benefits Package- A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the . . . Act.
(b) Cost-sharing Under Group Health Plans- A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).
(c) Child-only Plans- If a health insurance issuer offers health insurance coverage in [a metal level], the issuer shall also offer such coverage in that level [as a child only plan – less than 21].
(d) Dental Only- This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS

- (a) Essential Health Benefits Package- In this title, the term `essential health benefits package' means, with respect to any health plan, coverage that--
  - (1) provides for the essential health benefits defined by the Secretary under subsection (b);
  - (2) limits cost-sharing for such coverage in accordance with subsection (c); and
  - (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

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- (b) Essential Health Benefits-
  - (1) IN GENERAL- Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:
    - (A) Ambulatory patient services.
    - (B) Emergency services.
    - (C) Hospitalization.
    - (D) Maternity and newborn care.
    - (E) Mental health and 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.
    - (J) Pediatric services, including oral and vision care.

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(c) Requirements Relating to Cost-Sharing-

(1) ANNUAL LIMITATION ON COST-SHARING-

- (A) 2014- The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.
- (B) 2015 AND LATER- In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall--

SEC. 1302(c) cont'd

(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS-

(A) IN GENERAL- In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed--

- (i) $2,000 in the case of a plan covering a single individual; and
- (ii) $4,000 in the case of any other plan.

- The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement . . . section 106(c)(2) of the Internal Revenue Code of 1986 . . ..

(3) COST-SHARING- In this title—
(A) IN GENERAL- The term `cost-sharing' includes-(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan

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- (d) Levels of Coverage-
  - (1) LEVELS OF COVERAGE DEFINED- The levels of coverage described in this subsection are as follows:
    - (A) BRONZE LEVEL- A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.
    - (B) SILVER LEVEL- A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.
    - (C) GOLD LEVEL- A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.
    - (D) PLATINUM LEVEL- A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

Fed' l Regulatory Action

- December 2011 Bulletin and February FAQs
- State opportunities to select a benchmark plan
- No federal proposed regulation yet

Status and Prognosis of EHB

- Other states
- DOI steps taken & other states
- Data compiled from carriers by DOI and in healthcare.gov

Issues re: benefits

- Unclear to what extent HHS might determine supplement necessary
- Common areas supplemented
- No expected increased / add'l costs due to Idaho Mandates

Conclusion

- EHB –
  - 10 categories of benefits,
  - cost-sharing limits HDHP (2013 $6,250 self, $12,500 family),
  - metal plan AV levels of coverage
- HHS Bulletin and FAQs – no Reg. yet . . .
- No clear consensus from states – ID monitoring and should still have an opportunity to select a benchmark – once federal default announced

Questions?

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