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ESSENTIAL HEALTH BENEFITS PACKAGE

This document provides the Essential Health Benefits Work Group of the Advisory Task Force with an overview of the statutory and regulatory guidelines on Essential Health Benefits (EHB), as well as the critical questions the Task Force is asked to answer. Work Group members should develop and record recommendations, and submit them to the Advisory Task Force and to the New Mexico Human Services Department.

HUMAN SERVICES DEPARTMENT

New Mexico Health Insurance Exchange Advisory Task Force

Background Information

The Patient Protection and Affordable Care Act (ACA) mandates that certain health benefit plans sold in the individual and small group markets, both inside and outside of the exchange, offer a comprehensive package of items and services, known as "essential health benefits" ("EHB") beginning in 2014. Section 1302(b)(1) of the ACA provides that, at a minimum, EHB include items and services within the following benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse 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

The Department of Health and Human Services ("HHS") intends for there to be an appropriate balance among the benefit categories. Benefits must be designed in a manner that does not discriminate based on age, disability, or expected length of life. Health care needs of diverse segments of the population must be taken into consideration. The scope of EHB must be equal to the scope of benefits provided under a typical employer plan. This approach recognizes that issuers make a holistic decision in constructing a package of benefits that aims to balance consumers'' needs for comprehensiveness and affordability. Proposed regulations on cost-sharing have not yet been issued.

In a bulletin issued on December 16, 2011, HHS outlined proposed policies that would give states the flexibility to select an existing health plan to set the "benchmark" for the items and services included in each state's EHB package. The selected benchmark plan will serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in the state. All health plans will be compared to the benchmark plan, and must offer benefits that are "substantially equal". If the benchmark plan chosen does not cover the state's mandated benefits, the state must defray the cost of these additional benefits.

Under HHS' intended approach, states would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group insurance products in the state's small group market
- One of the three largest state employee health plans (by enrollment)
- One of the three largest national Federal Employee Health Benefits Plan ("FEHBP") plan options by enrollment
- The largest insured commercial non-Medicaid HMO plan operating in the state

In a supplement to the above-referenced December bulletin, HHS identified each state's largest small group products using data from HealthCare.gov. As identified by HHS, in New Mexico these products, in rank order by enrollment, are Lovelace Insurance Company's Classic PPO (ID#58330NM150), Blue Cross Blue Shield of New Mexico's BlueNet EPO (ID#75605NM027), and UnitedHealthcare Insurance Company's Choice Plus (ID#90762NM001). The HHS supplement also identified the three largest national FEHBP plans as of March 31, 2012: Blue Cross Blue Shield (Standard Option), Blue Cross Blue Shield (Basic Option), and Government Employees Health Association (Standard Option). (Information on each plan's benefit offerings are provided in the respective links.)

Additional Resources:

Patient Protection and Affordable Care Act of 2010, P.L. 111-148, Section 1302 (42 U.S.C. §18022)

Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (Dec 16, 2011)

Frequently Asked Questions on Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (Feb 17, 2012)

Essential Health Benefits: List of the Largest Three Small Group Products by State, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services (Jul 3, 2012)

Essential Health Benefits: Balancing Coverage and Cost, Institute of Medicine (Oct 6, 2011)

Selected Medical Benefits, A Report from the Department of Labor to the Department of Health and Human Services (Apr 15, 2011)

HealthCare.gov

Questions

1. Which benefits within the 10 EHB categories are "essential"? Which benefits are the most/least important to have in a health plan? (Benefits may be ranked on the attached worksheet.)
2. If a benefit category is missing in the benchmark plan (e.g., habilitative services and/or pediatric oral and vision services), what methods or plans should the state use to supplement that missing category?
3. What should constitute "substantially equal" benefits when comparing a health plan to the benchmark in order to qualify the health plan?
4. When choosing a benchmark health plan, what kind of plan should be chosen and why? (small group plan, State employee plan, Federal employee plan, or a commercial HMO plan)

Please track additional questions that may emerge as part of this process. Work Group Leaders will summarize the recommendations from this group. Please submit any questions or written recommendations to the Work Group Leader.