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ESSENTIAL HEALTH BENEFITS FOR HEALTH INSURANCE PLANS

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A key addition to health insurance regulation under federal health care reform, also known as the Patient Protection and Affordable Care Act (PPACA), is the establishment of essential health benefits. Essential health benefits are a core set of health care services and coverage requirements that most fully insured health insurance plans in the individual and small group markets are required to include beginning in 2014. These essential health benefits apply to health insurance policies sold both in and out of the state-based health insurance exchanges created under PPACA.[1] Self-funded health plans, larger employer group plans, and certain other grandfathered plans are not required to offer essential health benefits.

This issue brief provides an overview of the essential health benefit categories and the process for selecting a benchmark plan for the essential health benefits. It discusses the benchmark plan selected by Colorado and how the costs associated with state-mandated health benefits are addressed under PPACA.

[1]Health insurance exchanges are marketplaces where consumers can shop for and purchase health plans. Persons with incomes between 100 and 400 percent of the Federal Poverty Level may qualify for federal subsidies to assist in paying the costs of health insurance purchased through exchange.

Essential Health Benefit Categories

States are required to select a benchmark plan that incorporates essential health benefits in ten categories, including:

- 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; and
- pediatric services, including oral and vision care.

Benchmark Plan Selection

While federal law defines the essential health benefit categories listed above, the federal Department of Health and Human Services (DHHS) delegated the responsibility of selecting a benchmark plan that incorporates these services to the states. The benchmark plan serves as a model for all health insurers in the state to offer

plans that meet the coverage requirements under PPACA. States were, at a minimum, required to consider and select their benchmark plans from the following types of health plans:

- one of the three largest small employer group plans in the state by enrollment;
- one of the three largest health plans for state government employees by enrollment;
- one of the three largest health plan options for federal government employees by enrollment; or
- the largest health maintenance organization plan offered in the state's commercial market by enrollment.

In states that fail to select a benchmark plan, the small employer group plan with the largest enrollment in the state is established as the benchmark plan by default. The benefits covered by the benchmark plan will be in effect for 2014 and 2015. The federal DHHS is expected to promulgate rules updating the process for selecting the essential health benefits for 2016.

Colorado's Selected Benchmark Plan

In Colorado, the Division of Insurance in the Department of Regulatory Agencies, the Colorado Health Benefit Exchange, and the Office of the Governor worked together to select the benchmark plan for the essential benefits required in Colorado. On August 31, 2012, these entities recommended that the state's largest small employer group plan, a Kaiser HMO plan, be selected as the benchmark. After a period for public comment, this recommendation was submitted to the federal DHHS as the state's official selection. The selected benchmark plan does not cover the essential health benefit of pediatric dental services, which must be added as a supplemental benefit to the benchmark plan. Colorado has selected the pediatric dental coverage under the Child Health Plan Plus to be used as the benchmark for this service.

State-mandated Health Benefits

Generally under PPACA, states must defray the additional costs for any state mandated health benefits in excess of the minimum essential health benefits that the federal government incurs when subsidizing health insurance premiums through state health insurance exchanges. However, for the two-year transition period in 2014 and 2015, if a state selects a state-regulated plan that includes state mandates for plans in both the individual and small group markets (as Colorado did with the Kaiser HMO plan), then the state does not have to pay for the cost associated with these state mandated benefits. As mentioned above, the federal DHHS will review its rules for the selection of essential health benefit benchmark plans for 2016, which could change how the costs of state mandated benefits are paid.