

Essential Health Benefits

Does the Essential Health Benefits (EHB) package become effective across the board on Jan. 1, 2014?

No. The EHB requirements become effective for each plan on the first day of the first plan year beginning on or after Jan. 1, 2014. They apply only in the fully insured Individual and Small Group markets, with grandfathered plans excluded.

Will EHBs vary based on the type of health plan product?

No. Fully insured Individual and Small Group plans that must have EHBs in 2014 include all products, whether it is an HMO, PPO, POS or high-deductible HRA/HSA.

What are the deductible caps for Small Group plans under the Affordable Care Act?

The Affordable Care Act of 2010 (ACA) establishes limits on deductibles for fully insured, non-grandfathered plans in the Small Group market at \$2,000 for individuals and \$4,000 for families. These limits will apply to the plan on the first day of the first plan year beginning on or after Jan. 1, 2014. These dollar amounts will be indexed for inflation each year. This requirement does not apply to grandfathered plans. The deductible ceiling applies only to fully insured Small Group plans. It does not apply to ASO plans or fully insured Large Group plans. For plans with network benefits, the limits apply only to the in-network deductible.

What are the out-of-pocket maximum limits under the ACA?

The ACA establishes limits on out-of-pocket maximums for non-grandfathered plans in the Individual, Small Group and Large Group markets. As with the deductible limits, the out-of-pocket limits will apply to the plan on the first day of the first plan year beginning on or after Jan. 1, 2014. Out-of-pocket maximums may not exceed the limitations imposed on HSA-qualified high-deductible health plans (\$6,350/single, \$12,700/family for 2014). In addition, all member cost-sharing must apply to the out-of-pocket maximum (e.g., copayments and deductibles). For plans with network benefits, the limits apply only to the in-network, out-of-pocket maximum. This requirement does not apply to grandfathered plans.

When will we know about the pricing impact of the EHB requirements on health plans?

The pricing impact is uncertain as we await more definition on how the 50 states select benchmark plans that will establish the scope of EHB packages for a “typical employer plan.” We also need more guidance on the four “metallic” tiers of coverage that will be required in and out of Exchanges.

Habilitative services are listed along with rehabilitative services and devices. What is the difference?

A **habilitative service** is a health service that allows a patient to acquire a functional skill that should be present but is absent due to sickness or injury. Example: speech therapy for a non-verbal child with autism.

A **rehabilitative service** is a health service that allows a patient to reacquire a functional skill that was previously present but has been lost due to sickness or injury: Example: speech therapy for an adult who has suffered a stroke.

In the Employer Mandate, do the employees who count against the 50-person limit all have to be full-time employees?

An employer with at least 50 full-time employees or a combination of full-time and part-time employees considered to be 50 full-time equivalents will be subject to the shared-responsibility provisions to provide minimum essential coverage for employees and their dependents. A Notice of Proposed Rulemaking on this provision was released on Dec. 28, 2012, and a comment period was open through the first quarter of 2013.

How will employers determine if their health plan provides minimum essential coverage?

The Internal Revenue Service (IRS) will work with the Department of Health and Human Services (HHS) to make available a minimum value calculator similar to the actuarial value calculator they have developed. Employers will be able to input certain information, such as deductibles and copayments, to get a determination as to whether the plan provides minimum value by covering at least 60 percent of the total allowed cost of benefits.

Are there any limitations on the waiting period before new hires can obtain health coverage?

In group markets of all sizes and funding, a maximum waiting period of 90 days will take effect on Jan. 1, 2014.

Will health plans have to exactly match the state-designated benchmark plans in terms of covered benefits?

No. Plans may have coverage that differs from the benchmark plan as long as covered benefits remain “substantially equal” and actuarially equivalent to those contained in the state EHB package.

Are there any EHB requirements specifically related to prescription drugs?

In order to meet the EHB requirements, a health plan must cover the greater of one drug in every category or class, or the same number of drugs in each category and class as the EHB benchmark plan.



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