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ESSENTIAL HEALTH BENEFITS PACKAGE

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You asked for information on the “essential health benefits package,” required by the 2010 federal health care reform act, including recent guidance from the U.S. Department of Health and Human Services (HHS) on certain benchmark plans. You also asked if the state’s mandated insurance benefits will be included in the benefit package.

SUMMARY

The federal Patient Protection and Affordable Care Act (PPACA) requires health plans that offer insurance coverage in the individual and small group markets to ensure that such coverage includes the essential health benefits package (EHB) for plan years beginning on and after January 1, 2014. PPACA (1) directs the HHS secretary to define the EHB and (2) requires the EHB to include 10 specific benefit categories. (For an overview of PPACA, see OLR Report [2010-R-0255](#).)

On December 16, 2011, HHS published a bulletin to provide information and solicit comments on the regulatory approach the department plans to propose for defining the EHB (available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf). HHS’ intended regulatory approach relies on states identifying a reference (benchmark) plan based on employer-

sponsored coverage available in the marketplace today, supplemented as necessary to ensure that the plan covers the 10 statutory categories of benefits. Thus, HHS proposes that each state select a benchmark plan that will serve as the EHB in that state. HHS suggests the following four benchmark plan types, from which each state will select one:

1. the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market,
2. any of the three largest state employee health benefit plans by enrollment,
3. any of the three largest national Federal Employees Health Benefit Program (FEHBP) plan options by enrollment, or
4. the largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

If a state does not select one of these, the largest plan in the state's small group market becomes the default benchmark plan, according to HHS.

Depending on the plan selected as a benchmark, current state mandated insurance benefits (e.g., mammograms, autism spectrum disorders, etc.) may be considered part of the EHB. We discuss this in more detail below. (For a list of state mandated health insurance benefits, see OLR Report [2011-R-0504](#).)

We have identified the largest state employee health plans and national FEHBP plan options, as described below. We are unable to determine the largest small group plan or HMO in the state at this time. The Connecticut Health Insurance Exchange Board of Directors has proposed establishing a multi-agency task force to identify, compare, and contrast the four benchmark plans that may be chosen as the EHB for Connecticut. According to the board's proposal (available at [http://www.healthreform.ct.gov/ohri/lib/ohri/exchange/1-19-12/ct-hix_bod_jan_2012_1.19.12_meeting_\(011712_draft\)_v4.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/exchange/1-19-12/ct-hix_bod_jan_2012_1.19.12_meeting_(011712_draft)_v4.pdf)), the task force would likely include the Health Insurance Exchange, Connecticut Insurance Department, Health Care Advocate, executive and legislative leaders, and key stakeholders. According to the Insurance Department, it has offered to help the Exchange gather the necessary information from insurance carriers to inform the board's work.

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PPACA requires health plans that offer insurance coverage in the individual and small group markets to ensure that such coverage includes the EHB for plan years beginning on and after January 1, 2014 (PPACA § 1302). According to HHS, non-grandfathered plans in the individual and small group markets (both inside and outside the Health Insurance Exchange) must cover the EHB. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the EHB. (A grandfathered plan is health insurance coverage that existed on March 23, 2010 and has not made significant changes since (PPACA § 1251).)

PPACA requires the EHB to include the following 10 specific benefit categories:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

The EHB must provide coverage in four benefit tiers: bronze, silver, gold, and platinum. These benefit levels differ in terms of the actuarial value of coverage. A bronze plan will cover 60% of the actuarial value of the EHB; silver will cover 70%; gold, 80%; and platinum, 90%. HHS's EHB guidance relates only to covered services. HHS plans on releasing guidance on calculating actuarial value in the near future.

STATE MANDATED INSURANCE BENEFITS

For qualified health plans (health plans approved to be sold on the Health Insurance Exchange beginning in 2014), PPACA requires a state to defray the cost of any benefits required by state law to be covered beyond the EHB. Thus, a state that requires additional mandates (above and beyond the EHB) in the plans sold on the exchange must pay for those benefits by either reimbursing the individual insured or the plan (PPACA § 1311(d)(3)).

According to HHS, state laws mandating coverage of certain benefits vary in number, scope, and topic across the states. But HHS' analysis of employer plans nationally suggests that most state-mandated benefits are typically included in benefit packages issued in states without the mandate. Additionally, the FEHBP plans, which are not subject to state mandated benefits, cover nearly all of the benefits mandated by states. The primary exceptions are mandates requiring coverage of in-vitro fertilization and applied behavioral analysis therapy for autism spectrum disorders (both of which Connecticut requires).

HHS' proposed regulatory approach for defining the EHB minimizes the likelihood that a state would be required to pay for the costs of the mandates in excess of the EHB. Since the state will select a benchmark plan that is available in today's marketplace, it is highly likely that the plan selected will contain all or nearly all of the benefits currently mandated.

According to HHS, for 2014 and 2015, if a state chooses a benchmark plan that is already subject to state mandates – such as a small group market plan – that would mean the state's EHB includes those mandates. Alternatively, if a state chooses a plan that is not subject to the state mandates, such as a FEHBP plan, PPACA requires the state to defray the cost of the state mandates that are outside of that state EHB plan.

HHS intends to evaluate the EHB and benchmark approach for calendar year 2016. At that time, HHS may develop an approach that may exclude some state mandates from the EHB.

THREE LARGEST STATE EMPLOYEE HEALTH BENEFIT PLANS

According to the State Comptroller's Office, the three largest Connecticut employee health benefit plans by enrollment are the (1) Anthem Point-of-Enrollment (POE) Non-Gated plan, (2) Anthem Point-of-

Service (POS) plan, and (3) Oxford POE Non-Gated plan. An overview of the plans is available at <http://www.osc.ct.gov/empret/healthin/2011hcplan/SOCActiveEmployees2011final8.26.pdf>.

Table 1 provides a brief summary of benefits for each of these three state employee plans.

Table 1: Summary of Benefits for Three Largest State Employee Plan Options

Benefit	Anthem and Oxford POE Non-Gated	Anthem POS
Annual deductible	\$350 each individual \$1,400 maximum for family Waived for employees enrolled in the Health Enhancement Program	In-network: Same as POE Non-Gated Out-of network: \$300 individual \$900 family
Annual out-of-pocket maximum	\$350 each individual \$1,400 maximum for family Waived for employees enrolled in the Health Enhancement Program	In-network: Same as POE Non-Gated Out-of-network: \$2,000 (plus deductible) individual \$4,000 (plus deductible) family
Coinsurance	None	In-network: None Out-of-network: The insured person pays 20% of allowable charge, plus 100% of any amount the provider bills over the allowable charge
Outpatient physician visits, walk-in centers, and urgent care centers	\$10 co-pay	In-network: \$15 co-pay Out-of-network: 80%
Preventive care	No co-pay for preventive care visits and immunizations	In-network: Same as POE Non-Gated Out-of-network: 80%
Inpatient physician, inpatient hospital, and outpatient surgical facility	100% (precertification required)	In-network: Same as POE Non-Gated Out-of-network: 80% (precertification required)
Ambulance	100% (if emergency)	100% (if emergency)
Mental Health	In-patient: 100% (pre-certification required) Out-patient: \$10 co-pay	In-network: <ul style="list-style-type: none"> • In-patient: Same as POE Non-Gated • Out-patient: \$15 co-pay Out-of-network: <ul style="list-style-type: none"> • In-patient: 80% (precertification required)

Table 1: (Continued)

Benefit	Anthem and Oxford POE Non-Gated	Anthem POS
		<ul style="list-style-type: none"> • Out-patient: 80%
Substance abuse	In-patient: 100% Out-patient: \$10 co-pay	In-network: <ul style="list-style-type: none"> • In-patient: 100% • Out-patient: \$15 co-pay Out-of-network: <ul style="list-style-type: none"> • In-patient: 80% • Out-patient: 80%
Skilled nursing facility	100% (precertification required)	In-network: Same as POE Non-Gated Out-of-network: 80%, up to 60 days per year (precertification required)
Home health care	100% (precertification required)	In-network: Same as POE Non-Gated Out-of-network: 80%, up to 200 visits per year (precertification required)
Hospice	100% (precertification required)	80%, up to 60 days (precertification required)
Short term rehabilitation and physical therapy	100%	In-network: 100% Out-of-network: 80%, up to 60 inpatient days and 30 outpatient days per condition per year
Pre-admission testing, diagnostic X-ray, and lab	100% (precertification required for diagnostic imaging)	In-network: Same as POE Non-Gated Out-of-network: 80% (precertification required for diagnostic imaging)
Emergency care	100% (co-pay may apply)	100% (co-pay may apply)
Durable medical equipment and prosthetics	100% (precertification required)	In-network: Same as POE Non-Gated Out-of-network: 80% (precertification required)
Routine eye exam	\$15 co-pay, one exam per year	In-network: Same as POE Non-Gated Out-of-network: 50%, one exam every two years
Audiological screening	\$15 co-pay, one exam per year	In-network: Same as POE Non-Gated Out-of-network: 80%, one exam per year

Source: State of Connecticut – Office of the State Comptroller

Table 2 provides the 2011-2012 monthly premium rates for each plan.

Table 2: Premium Rates for Three Largest State Employee Plan Options (2011-2012)

<i>Plan</i>	<i>Monthly Premium Rate (\$)</i>
Anthem POE Non-Gated:	
• Employee	604.18
• Employee +1	1,329.20
• Family	1,631.29
• Family Less Employed Spouse (FLES)*	1,027.11
Anthem POS:	
• Employee	624.24
• Employee +1	1,373.33
• Family	1,685.45
• FLES	1,061.21
Oxford POE Non-Gated	
• Employee	481.97
• Employee +1	1,060.33
• Family	1,301.32
• FLES	819.35

Source: State of Connecticut – Office of the State Comptroller

* The FLES rate is available only when both spouses are employed by the state, eligible for health insurance, and enrolled in the same plan, along with at least one child.

THREE LARGEST NATIONAL FEHBP PLAN OPTIONS

The three largest national FEHBP plans by enrollment are the (1) Blue Cross and Blue Shield (BCBS) Standard Option, (2) BCBS Basic Option, and (3) Government Employees Health Association (GEHA) Standard Option. Summary plan booklets are available at

<http://www.opm.gov/insure/health/planinfo/2011/brochures/71-005.pdf> and

<http://www.opm.gov/insure/health/planinfo/2011/brochures/71-006.pdf>.

Table 3 provides a brief summary of benefits for each of these three FEHBP plans. The description indicates the amount the insured person pays for the listed benefit.

Table 3: Summary of Benefits for Three Largest FEHBP Plan Options (2012)

<i>Benefit</i>	<i>BCBS Standard</i>	<i>BCBS Basic</i>	<i>GEHA Standard</i>
Physician services:			
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; \$20 per office visit for primary care physicians and other health care professionals; \$30 per office visit for specialists; 15%* of other covered services Non-PPO: 35%*	PPO: Nothing for preventive care; \$25 per office visit for primary care physicians and other health care professionals; \$35 per office visit for specialists Non-PPO: You pay all charges	PPO: \$10 per office visit for primary care physician; \$25 per office visit for specialist; 15%* of other covered services, including X-ray and lab Non-PPO: 35%*
Hospital services:			
<ul style="list-style-type: none"> Inpatient 	PPO: \$250 per admission Non-PPO: \$350 per admission, plus 35%	PPO: \$150 per day up to \$750 per admission Non-PPO: You pay all charges	PPO: 15%* Non-PPO: 35%*
<ul style="list-style-type: none"> Outpatient 	PPO: 15%* Non-PPO: 35%*	PPO: \$75 per day per facility Non-PPO: You pay all charges	PPO: 15%* Non-PPO: 35%*
Emergency benefits:			
<ul style="list-style-type: none"> Accidental injury 	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between the Plan allowance and the billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport: Nothing	PPO: \$125 for emergency room care; \$50 for urgent care Non-PPO: \$125 for emergency room care Ambulance transport: \$100 per day for ground ambulance; \$150 per day for air or sea ambulance	PPO and Non-PPO: Nothing up to Plan allowance of covered charges incurred within 72 hours
<ul style="list-style-type: none"> Medical emergency 	PPO and Non-PPO: 15%* for emergency room care; regular benefits for physician and hospital care* provided in settings other than emergency	PPO: \$125 for emergency room care; \$50 for urgent care Non-PPO: \$125 for emergency room care	PPO and Non-PPO: Regular benefits

Table 3: (Continued)

Benefit	BCBS Standard	BCBS Basic	GEHA Standard
	room Ambulance transport: \$100 per day for ground ambulance; \$150 per day for air or sea ambulance	Ambulance transport: \$100 per day for ground ambulance; \$150 per day for air or sea ambulance	
Mental health and substance abuse treatment	PPO and Non-PPO: Regular cost-sharing (see physician services and hospital services above)	PPO: Regular cost-sharing Non-PPO: You pay all charges	PPO and Non-PPO: Regular cost-sharing
Prescription drugs	Retail pharmacy program: <ul style="list-style-type: none"> • PPO: 20% generic; 30% preferred brand-name; 45% non-preferred brand name; 30% specialty; up to a 90-day supply • Non-PPO: 45%; up to a 90-day supply Mail order program: <ul style="list-style-type: none"> • \$15 generic; \$70 preferred brand name; \$95 non-preferred brand name; up to a 90-day supply Specialty drug program: <ul style="list-style-type: none"> • \$80, up to a 90-day supply 	Retail pharmacy program: <ul style="list-style-type: none"> • PPO: \$10 generic; \$40 preferred brand name; 50% (\$50 minimum) non-preferred brand name; \$50 specialty; 34-day supply on initial; up to 90-day supply for refill, with three copays • Non-PPO: You pay all charges Specialty drug program: <ul style="list-style-type: none"> • \$40; 34-day supply on initial; up to 90-day supply for refill, with three copays 	Retail pharmacy program: <ul style="list-style-type: none"> • PPO: You pay lesser of \$5 or the usual and customary (U&C) cost for generic; 50% brand name up to a maximum of \$200 for up to a 30-day supply • Non-PPO: You pay lesser of \$5 or the U&C cost for generic; 50% brand name up to a maximum of \$200 for up to a 30-day supply and any difference between the Plan allowance and the cost of the drug • Cost sharing goes toward a \$6,000 annual Rx out-of-pocket limit, except for 70% co-insurance for non-preferred sleep aid drugs Mail order program: <ul style="list-style-type: none"> • You pay lesser of \$15 or the cost of the drug for generic; 50%

Table 3: (Continued)

Benefit	BCBS Standard	BCBS Basic	GEHA Standard
			brand name up to a maximum of \$500 for up to a 90-day supply <ul style="list-style-type: none"> • Cost sharing goes toward a \$6,000 annual Rx out-of-pocket limit, except for 70% co-insurance for non-preferred sleep aid drugs
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	PPO: \$25 per evaluation (exam, cleaning, and X-rays); most services limited to two per year; sealants for children up to age 16; \$25 for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions
Out-of-pocket maximum	PPO: You pay nothing after \$5,000 per contract year Non-PPO: You pay nothing after \$7,000 per contract year Some costs do not count toward the out-of-pocket maximum	PPO: You pay nothing after \$5,000 per contract year Non-PPO: no maximum; you continue to pay charges Some costs do not count toward the out-of-pocket maximum	PPO: You pay nothing after \$5,000 per contract year Non-PPO: You pay nothing after \$7,000 per contract year Some costs do not count toward the out-of-pocket maximum

Source: U.S. Office of Personnel Management

* This item is subject to deductible, as follows:

- BCBS Standard has a \$350 per person and \$700 per family calendar year deductible.
- GEHA Standard has a \$350 calendar year deductible.

Table 4 provides the 2012 monthly premium rates for each plan.

Table 4: Premium Rates for Three Largest FEHBP Plan Options (2012)

<i>Plan</i>	<i>Monthly Premium Rate (\$)</i>
BCBS Standard:	
• Self	587.88
• Family	1,327.80
BCBS Basic:	
• Self	487.54
• Family	1,141.70
GEHA Standard:	
• Self	370.39
• Family	843.46

Source: U.S. Office of Personnel Management

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