Health Care Reform: Essential Health Benefits

The Affordable Care Act of 2010 (ACA) requires insurers to provide coverage for an Essential Health Benefits (EHB) package in 10 benefit categories, effective the first plan year on or after January 1, 2014.

These requirements apply to all fully insured health plans offered in the Individual and Small Group insured markets (both inside and outside of Exchanges). EHB requirements do not apply to ASO plans (regardless of group size), fully insured Large Group plans or any grandfathered plans.

The Essential Health Benefits package encompasses these 10 benefit categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Laboratory services
5. Maternity and newborn care
6. Mental health and substance abuse services, including behavioral health treatment
7. Prescription drugs
8. Rehabilitative and habilitate services and devices
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

What's In Scope and Out of Scope?
The requirement to add Essential Health Benefits applies to all non-grandfathered Individual plans and non-grandfathered, fully insured Small Group plans inside and outside of Exchanges.

What are the most common non-covered benefits:
The following Essential Health Benefit categories have not generally been covered under most typical employer plans:

- Habilitative services
- Pediatric oral services
- Pediatric vision services

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.

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 January 1, 2014. Out-of-pocket maximums may not exceed the limitations imposed on HSA-qualified high-deductible health plans ($6,400/single, $12,800/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.

What are the cost-sharing rules for the essential health benefits?

The ACA links the essential health benefits package to limits on cost-sharing. So health plans that are required to provide essential health benefits will also be required to limit the amount consumers will have to pay out-of-pocket. Specifically, health plans will be prohibited from requiring consumers to pay annual cost-sharing that is greater than the limits for high deductible plans linked to health savings accounts. Currently, those limits are $5,950 per year for individuals and $11,900 per year for families. In addition, small group plans must limit deductibles to $2,000 for individual coverage and $4,000 for family coverage.

Note that States who currently do not have all ten of the essential health benefits in their respective states have until 2016 until requiring all insurance carriers in their states to comply.