ADDITIONAL GUIDANCE ISSUED ON ESSENTIAL HEALTH BENEFITS

This installment of Hall Render's Health Law Broadcast series on health care reform is designed to provide you with the insight, analysis and practical suggestions with respect to the various reform initiatives that will affect your organization.

The U.S. Department of Health and Human Services ("HHS") recently issued additional guidance regarding the essential health benefits ("EHB") that must be offered by insurance plans operating in the individual and small group markets.

Beginning in 2014, the Affordable Care Act (the "Act") will require all non-grandfathered plans sold in the individual and small group market to provide certain EHB.

Section 1302(b)(1) of the Act provides that EHB include items and services within at least the following 10 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.

A grandfathered health plan is an existing group health plan or health insurance coverage in which a person was enrolled on March 23, 2010, the date of enactment of the Act. States may have different requirements for the individual and small group markets. Typically, however, the individual market consists of people who do not get health coverage through their employer or through some type of government program, while the small group market consists of employers having at least 2 but not more than 50 employees.

Prior to this most recent guidance, HHS released a Bulletin describing the approach that it intends to take in future rulemaking to define the EHB under the Act. (A copy of the Bulletin is available here.) HHS announced that the EHB would be defined by a benchmark plan selected by each State, similar to the approach established by Congress for the Children's Health Insurance Program ("CHIP").

As a supplement to that initial Bulletin, HHS issued a list of frequently asked questions ("FAQ") to provide additional information on HHS' intended approach to defining EHB. Among other things, the FAQ clarifies how and when a State would be required to select a benchmark plan. A copy of the FAQ is available at:
http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

For providers who are looking to diversify their service lines or patient population needs, this guidance should be considered.

If you have any questions or would like additional information about this topic, please contact

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