Proposed Essential Health Benefits (EHB) Overview
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Prepared by DC HRIC Insurance Subcommittee
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Topic	Citation #(Page #)	Summary	Impact on District
Definitions	156.20 (pp. 18-19)	"Base-benchmark plan": the plan that is selected by the District, prior to any adjustments made to meet benchmark standards.	District's base-benchmark plan in the CareFirst BlueCross BlueShield Blue Preferred PPO Option 1
		"EHB-benchmark plan": standardized set of essential health benefits that must be met by a QHP or other insurance carrier as required.	
		"EHB-package": the scope of covered benefits and associated limits of a health plan offered by an insurance carrier.	
Benefit Substitution	156.115 (a)(1)	Carriers must ensure that a health benefit plan provide benefits that are substantially equal to the EHB-benchmark plan, including:	(p.31)- "proposed benefit substitution policy does not apply to prescription drug benefits." (p.31)- "any substituted benefit… (must be) actuarially equivalent to the original benefit or benefits contained in…benchmark." D.C. has authority to enforce a stricter substitution standard (HBX Board)
		• Covered benefits	
		• Limitations of coverage including coverage of benefits amount, duration and scope; and	
		• Prescription drug benefits	

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Prescription Drug Benefits	156.120	Health plans do not meet EHB requirements unless it covers one drug in every USP category or provides the same number of drugs in each category and class as the EHB-benchmark plan	Follow up with carriers and stakeholders to identify potential issues.
	(p.34)	Propose that drugs listed in plan formulary be "chemically distinct." (Example- offering two dosage forms or strengths of the same drug would not be offering two drugs that are chemically distinct. Offering two brand name drugs and its generic equivalent is another example of drugs that are not chemically distinct	
Prohibition on Discriminatory Benefit Design	156.125 (pp.35-37)	Interpreted by CCIIO to be a prohibition on discrimination by carriers.	Codification of ACA prohibitions- no major impact on implementation assumptions
		A carrier does not comply with EHB regulations if it's benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected life span, or health condition	
	156.200	Prohibits discrimination based on race, disability, and age	
Cost-Sharing Requirements	156.130 (pp. 38-43)	Defined as "any expenditure required by or on behalf of an enrollee with respect to EHB… (including) deductibles, coinsurance, copayments, or similar charges, but excludes premiums…non-network providers, and spending for non-covered services."	Clarification of ACA
		Prohibition on annual limits begins with plan years beginning on or after January 1, 2014. Annual limitation of cost-sharing should be increased by the premium adjustment percentage (set by HHS) in years after 2014 for Self-Only coverage. Annual limitation for Non-Self coverage is double the annual limitation on Self-only coverage	

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Deductibles (Small Group Market)	156.130(b)	$2,000 for Self-only coverage; $4,000 for Non-Self coverage. Subsequent years: see above scenario.	
		Carriers can make adjustments to its deductible to maintain the specified AV for the applicable level of coverage----a plan may exceed the annual deductible limit id it cannot reasonably reach a given level of coverage	Staff needs to evaluate potential impacts on design and affordability.
	(p.40)	HHS proposes "to use a 'reasonableness' standard…to determine…whether a specific variation threshold should be identified, and if so, how any such threshold should be established."	Determine if the District or stakeholders will weigh on proposed standard.
	156.130 (f)	Annual deductibles do not apply to preventative care	
Out-of-network Cost-Sharing	156.130 (c)	Cost-sharing requirements for benefits from a provider outside of a plan's network do not count towards annual limitations on cost-sharing	
Adjustments to Benefit Plan Cost-Sharing	156.130 (d)	Annual limitation on cost-sharing and the annual limitation on deductibles for a plan year beginning after calendar year 2014 only increase by multiples of $50 and must be rounded to the next lowest multiple of $50.	
Actuarial Value (AV) Calculation	156.135 (pp.43-50)	Propose that carriers use the AV calculator developed by HHS to determine the appropriate "metal levels" of coverage.	HHS seeks comment on this approach and methodology of the AV calculator.
		The proposed AV calculator will be developed using a set of claims data weighted to reflect the standard population projected to enroll in the individual and small group markets for the identified year of enrollment.	
Levels of Coverage	156.140 (pp.50-51)	Proposes a de minimis variation of +/- 2 percentage points for all non-grandfathered plans with regard to their AV.	
		Codifies "metal level" AVs.	

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Stand-Alone Dental Plans	156.150	Reiterates ACA 131(d)(2)(B)(ii), which "allows the pediatric dental component of the EHB to be offered through a stand-alone dental plan."	
		Reiterates ACA 1302(b)(4)(F) that permits QHPs to exclude coverage of the pediatric dental component of the EHB if stand-alone plans are offered in the Exchange.	
		Dental plans must demonstrate the annual limitation on cost sharing for the stand-alone dental plan is reasonable for coverage of the pediatric EHB (only applicable to in-network services)	HHS requesting comment on this approach
AV Calculations for Stand-Alone Dental Plans	156.150(b) (p.56)	"Any stand-alone dental plan certified to meet a 75 percent AV, with a de minimis range of +/- 2 percentage points to be considered a "LOW" plan and anything with an AV of 85 percent (same de minimis range) be considered a "HIGH" plan.	Follow up with Board and stakeholders to determine appropriateness of approach. Review materials from past dental carrier meetings to identify consistencies/inconsistencies.
		Prohibits dental carriers from using HHS AV calculator, but "when (/if) pediatric dental EHB is included in a health plan, the AV calculator would apply to the pediatric dental EHB."	