



HEALTH CARE REFORM – SPECIAL EDITION

Institute of Medicine Issues Long-Awaited Report on Essential Benefits

LEGISLATIVE BRIEF

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On October 6, 2011 the Institute of Medicine (IOM) issued its long-awaited [report](#) on "essential health benefits." The Department of Health and Human Services (HHS) is charged with issuing regulations to further define the 10 categories of "essential benefits"--the minimum set of benefits that PPACA requires all health insurance policies in the individual and small group markets to provide as of January 1, 2014. HHS is expected to issue these regulations sometime in 2012, now that it has received guidance from the IOM, a federal advisory panel. The 297-page report outlined the criteria and methods HHS should use in developing its regulations and stressed affordability and breadth of coverage, stating:

"The [essential benefits package] must be affordable, maximize the number of people with insurance, protect the most vulnerable individuals, promote better care, ensure stewardship of limited financial resources by focusing on high value services of proven effectiveness, promote shared responsibility for improving our health, and address the medical concerns of greatest importance to us all."

Although larger employers and self-funded plans are not required to provide "essential benefits," their plan designs will be shaped by the government's eventual list of essential benefits, because employees will likely compare their group health coverage to health policies available on the health insurance exchange, and will likely expect their employer coverage to provide benefits that are at least as good as those provided by the health insurance exchange policies.

PPACA section 1302 defines 10 broad categories of "essential benefits"--a package of diagnostic, preventive and therapeutic services and products that small group and individual health insurance policies will be required to cover--and requires HHS to issue regulations to specifically define what constitutes minimum benefits in these 10 categories and what items and services must be covered within those categories. The 10 categories are—

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

One difficulty HHS faces in formulating the details of what items and services must be provided within the 10 broad categories—and how frequently they must be provided—is that the package must be broad enough to provide comprehensive benefits but not be so broad that the coverage it requires is unaffordable. The cost of coverage will be paid not only by employers, employees, and individual policyholders, but also by taxpayers generally, since PPACA provides broad federal government subsidies for taxpayers with household incomes of up to 400% of the Federal Poverty Level.

In the past, benefit plan design has been determined by insurance companies and by employers who buy the policies or who sponsor their own self-funded group plans. PPACA will change that in 2014, when it specifies the "essential benefits" that must be covered by health insurance policies in the individual and small group market. The intent is that the essential benefits will reflect the benefits provided in a "typical" employer group health plan. Plans can exclude from coverage those medical benefits and services that are not considered essential.

Employers should watch for the "essential benefits" regulations that will be issued by HHS some time in the next six to 12 months. These will determine the minimum benefit packages starting in 2014, and the benefit packages will drive the cost of health care.

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