

Essential Health Benefits Market Rules and Requirements (2014)

NOTE: This document was developed as a resource for carriers for product design purposes and to ensure compliance with the essential benefits requirements. It should be noted, however, that this document should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state and federal insurance laws and associated rules and regulations. It is the responsibility of the carriers to ensure that their products comply with all relevant statutory and regulatory requirements.

1. Essential Health Benefits (known as EHBs) establish a minimum level of coverage that apply to all non-grandfathered major medical health insurance plan policy forms, including HMOs, PPOs, and health services plans offered on and off the Health Benefits Exchange by a health insurance issuer in the individual and small group markets.
2. Carriers may choose to offer coverage that exceeds EHB benchmark minimum levels, but may be required to submit additional premium information for any benefits that exceed these minimums for plans to be sold inside the Exchange.
3. EHBs do not apply to large group health insurance plans or Medicare Supplemental insurance plans. However, prohibitions on annual and lifetime dollar limits on EHBs apply to all group sizes.
4. Actuarially equivalent substitutions within an EHB category are permitted. Carriers should note however, that the use of such substitutions may result in significant delays in the review of their form and rate filings, a consequence of which may be the failure to receive necessary review responses in time to meet critical deadlines.
5. Coverage for obstetrical services and prosthetic devices and components (mandated offers under Code of Virginia §§ 38.2-3414 and 38.2-3418.15, respectively) must be included in the EHB package. Coverage for the treatment of morbid obesity, Code of Virginia § 38.2-3418.13, must be offered and made available with any policy/plan. The mandated offer for child health supervision services and required deductible and coinsurance options are rendered irrelevant due to the EHB and ACA requirements.
6. Routine adult dental services, routine adult vision services, long-term care/custodial nursing home care and cosmetic orthodontia may, but are not required to be, included in a plan. These services may have annual or lifetime dollar limits.
7. Any cost-sharing for pediatric vision benefits, as well as all other EHBs, must be included in the annual limit on cost-sharing.
8. Drugs must be chemically distinct to be counted separately in the number of drugs offered in a category or class for the pharmacy benefit. Therefore, a brand name drug

and the equivalent generic drug would not count as two separate drugs. A different dosage size is not considered chemically distinct.

9. The out-of-pocket maximums for in-network services may not exceed the maximums for high deductible health plans. For calendar year 2013, those maximums are \$6,250 (individual) and \$12,500 (family).

For only the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums (such as vision or prescription drug), the maximums can be met separately if such maximums do not exceed the maximum dollar amount prescribed by federal law in §1302(c)(1) of the ACA. Maximums for mental health and substance use disorder benefits may not be separated under this provision.

10. For 2014, the annual limit on deductibles for plans in the small group market shall not exceed \$2,000 for single/ \$4,000 for family for in-network services.

A health plan's annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage (metal level) without excluding the annual deductible limit.

11. A catastrophic plan may only be offered in the individual market, and sold to an individual who has not attained the age of 30 before the beginning of the plan year or the individual has a certification indicating exemption or hardship.
12. If there is a stand-alone dental plan (SADP) offering pediatric dental benefits inside the Exchange, then a qualified health plan (QHP) that includes such benefits may segregate those benefits from the remainder of the QHP so that the QHP may be purchased without pediatric dental benefits.
13. Carriers offering plans outside of the Exchange may provide EHB coverage that excludes pediatric dental benefits if the carrier can be "reasonably assured" that such coverage is sold only to persons in the individual and small group markets who purchase Exchange certified SADPs.