National Retail Federation
The Voice of Retail Worldwide

Essential Health Benefits Final Rule – National Retail Federation's Top-Line Summary

EHB coverage will shape coverage in the individual and small group insurance markets. New coverage mandates likely will increase coverage costs. Large, self-funded employers cannot have annual or lifetime limits on EHBs covered in their plan.

	**Existing State Benefit Mandates** • § 155.170. See rule, pp. 17-20.	• State-enacted mandates included in EHB if enacted before 12/31/11 • *NRF opposed inclusion*; likely will increase coverage costs. • NRF urges scientific, evidence-based review of all existing state mandates by 2016 to help reduce costs.
	**Medical Management** • §156.125. See pp. 50-54.	• Clarified that legitimate, evidence-based medical management of benefits does not violate anti-discrimination rules. • For example, vaccine for Shingles is not medically indicated until age 60 or later. • *NRF supported this approach*.
	**Mental Health Parity, Coverage** • §156.115(a)(2). See rule, pp. 42-43.	• ACA requires inclusion of mental health benefits through the EHB to the small group and individual markets. • Regulation expands the Mental Health Parity Act provisions to small group and individuals, both explicitly excluded from the MHPA. • This will be a significant challenge to small group and individuals from both a cost and flexibility standpoint. • *NRF opposed extension of parity requirements*; will add cost and additional unwanted complexity in the 2014 transition.
	**Prescription Drug Coverage** • §156.122. See rule, pp. 46-50.	• Regulation bypassed calls to include six protected classes (e.g. Medicare) and instead will require **the greater of** one drug in each USP (U.S. Pharmacopeial Convention) category **or** the same number of drugs in each category and class as the benchmark EHB plan. • *NRF supported this approach*.
	**HSAs / HRAs & Value Calculations** • §156.135. See pp. 59-58.	• Initially only the insurance portion of a linked Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) counted toward actuarial value calculations. • Regulation counts employer contributions in full. For example, a $1,000 deductible plan becomes a zero deductible plan if the employer pre-funds the HSA portion with $1,000, thus giving the plan a higher actuarial value score.

		• *NRF supported this approach.*
	**Pediatric Vision and Dental** • §156.110. See rule, pp. 34-42.	• Requires pediatric vision and dental coverage. • Determined by: State coverage or supplementation through FEDVIP (federal employee program) or CHIP (State Children's Health Insurance Program. • *NRF opposed inclusion of this non-standard benefit.* Well-baby and well-child visits serve the same purpose with medically appropriate referrals as needed.
	**Habilitative Coverage** • §156.110. See rule, pp. 34-42.	• Helps a person learn, keep or improve skills and functional abilities that they may not be developing normally. • *NRF urged that this non-standard benefit not be included*; likely will increase cost. If included, policymakers should consider parity to rehabilitative coverage to provide some bounds to a potentially unlimited benefit given elimination of lifetime caps and (by 2014) annual limitations.
	**Minimum Value** • §156.145. See pp. 69-74.	• Even if a large plan is not subject to the EHB requirements, it still must provide coverage of "minimum value" of no less than 60%. • Options will include a MV calculator, a checklist of design-based safe-harbors, or actuarial certification. In some cases, carve-out benefits will have to be considered separately, without the MC calculator. • *NRF supported this approach because of the added flexibility*.
	**Out-of-Network Cost Sharing** • §145.130. See pp. 54-59.	• Out-of-network cost sharing generally does not count against cost-sharing limits. • Emergency room care (in or out) is an exception. Cannot have different cost-sharing or co-pays for out-of-network emergency room services. • *NRF supported this approach*.