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Essential Health Benefits. States have determined the minimum set of benefits to be included in individual and small-group insurance plans. What's next?

WHAT'S THE ISSUE?

The Affordable Care Act requires that health insurance plans sold to individuals and small businesses provide a minimum package of services in 10 categories called "essential health benefits." These include hospitalization, maternity and newborn care, ambulatory care, and prescription drugs.

But rather than establishing a national standard for these benefits, the Department of Health and Human Services (HHS) decided to allow each state to choose from a set of plans to serve as the benchmark plan in their state. Whatever benefits that plan covers in the 10 categories will be deemed the essential benefits for plans in the state.

This approach has drawn criticism from health care providers, consumer groups, and patient advocates, who would prefer a national standard. But it has been more welcomed by states and the business community, who appreciate the flexibility that the arrangement will afford states to tailor benefits to local circumstances. This policy brief explores the background of the debate and the policy implications surrounding essential health benefits.

WHAT'S THE BACKGROUND?

Historically, there has been no uniform national standard for health insurance benefits. Health insurance is primarily regulated at the

state level, with the exception of self-insured plans, which are subject to certain federal requirements that don't include a minimum benefit package. All states mandate that certain benefits must be covered, but these mandates vary from state to state. Coverage for core services—such as inpatient hospital care, outpatient procedures, and primary care visits—generally is not mandated, but almost all plans cover them.

Other services, such as home health and hospice care, are less widely covered. Many plans in the individual and small-group market (generally for companies with 100 or fewer employees) have lacked certain key benefits, such as substance abuse services, or offer little security to patients with even some common health care needs. For example, HHS estimates that 62 percent of plans in the individual market do not provide maternity coverage, 18 percent do not cover mental health services, and 9 percent do not cover the cost of prescription drugs.

efits should be required in a health plan is a balancing act between comprehensiveness and cost; the more inclusive the package, the higher the cost. To reduce the number of Americans who are uninsured or underinsured, policy makers sought to create a required benefit package that is both affordable—by keeping in check the total cost of coverage—and that also provides "meaningful"

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Essential health benefits

Insurance plans for individuals and small businesses must provide at least 10 categories of "essential health benefits." coverage—by protecting enrollees from high out-of-pocket costs for needed care.

Beginning in 2014 health plans sold in the individual and small-group markets, both within and outside the new state-based exchanges, must include essential health benefits. The requirements also apply to benefits provided to the population that will be newly eligible for Medicaid coverage. These requirements do not apply to self-insured health plans, those in the large-group market (generally companies with more than 100 employees), or grandfathered health plans (those in existence at the time the Affordable Care Act was signed into law).

REQUIRED CATEGORIES: The law specifies that benefits must include services in at least 10 categories and equal the scope of benefits covered in "a typical employer plan" (Exhibit 1). In addition, the law requires HHS to take into account the health care needs of diverse populations in defining essential benefits. If a state requires coverage of a specific benefit that is not included in the federal package, the state must cover the cost for enrollees in plans subject to the requirement.

Prior to issuing guidance on the essential health benefits package, HHS held listening sessions with consumers, providers, insurers, and employers. It also commissioned a report from the Institute of Medicine (IOM) on the process it should use for devising the package. In its report released in October 2011, the committee convened by IOM emphasized the importance of keeping the essential health benefits package affordable for small employers, consumers, and taxpayers, and it recom-

mended a framework for selecting benefits and covered services that would focus on medical effectiveness. The IOM committee explicitly stated that state-mandated benefits should not automatically be covered but should instead be subject to the same medical effectiveness review process and criteria as other benefits.

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In a departure from the approach set out by the IOM committee, which anticipated that HHS would define a national benefits package, HHS announced that each state must set its own definition of essential benefits for 2014 and 2015 by choosing a benchmark plan. States could choose from among the following:

- one of the three largest small-group plans in the state by enrollment,
- one of the three largest state employee health plans by enrollment,
- one of the three largest federal employee health plans by enrollment, or
- the largest health maintenance organization (HMO) plan offered in the state's commercial market by enrollment.

In each state, the same benchmark plan will apply to both the individual and small-group markets. States may choose the same or a different plan for the Medicaid population.

The federal regulations do not require insurers to replicate the benefits in the benchmark plan; rather, the benefits offered must be "actuarially equivalent" to those in the benchmark plan, meaning that the benefits are of approximately the same value in each of the 10 required categories. If a state does not select a plan, the default benchmark plan will be the plan with the largest enrollment in the state's small-group market.

HHS has indicated that this overall approach may be changed in 2016 and in future years based on evaluation and feedback.

plan does not include one or more of the 10 categories, the state must supplement the plan with the relevant categories of benefits from another benchmark plan option. For pediatric oral and vision benefits, the state can choose to supplement with benefits from the federal employee insurance plan or from the state's Children's Health Insurance Program.

EXHIBIT 1

Minimum Set of Essential Health Benefits Required by the Affordable Care Act

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

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74%

Of required benefits

One analysis concluded that existing individual plans cover only about 74 percent of required benefits on average.

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Habilitative services are not commonly covered in private plans and are poorly defined. If the benchmark does not include habilitative services, HHS allows states to determine what services fall into this category. If a state does not define these services, then the plan may provide the same coverage as provided for rehabilitation services or can separately define habilitative services and report that definition to HHS.

STATE-MANDATED BENEFITS: All states have benefit mandates ranging, for example, from commonly offered services, such as emergency department services or diabetic supplies, to less standard benefits, such as in vitro fertilization and applied behavior treatment for autism.

If a state requires benefits that exceed those included in the essential health benefits package, then the Affordable Care Act requires the state to directly pay the cost of these additional mandates. Exchanges will be responsible for determining what, if any, state-required benefits exceed the package of essential health benefits. Plans would then calculate the costs of providing those benefits, and the state would pay either the plan or the enrollee for those costs.

However, most benefit mandates are included in the plans from which each state selected its benchmark plan. For the purpose of calculating costs, HHS has clarified that all staterequired benefits enacted prior to December 2011 are considered to be included in the essential health benefits. Some are concerned that these state-required benefits increase costs and might make plans unaffordable, although HHS estimates that inclusion of these benefits will have negligible effect on plan premiums. Groups representing employers and insurers hope that inclusion of state-mandated benefits will be reconsidered by 2016, and that only benefits supported by strong evidence of medical effectiveness will then be included in the essential health benefits package.

INITIAL RESPONSE: The federal government's decision on the approach to essential health benefits was generally well received by states, health plans, and the business community. Permitting states to draw the essential health benefits package from insurance policies that are already offered and that are popular in each state minimizes the need for insurers to make changes and allows small employers to continue coverage that is similar to what they already offer. Officials from

several states praised the HHS approach, particularly given the time constraints that states face in setting up health insurance exchanges where the health plans providing the essential benefits packages will be sold.

However, the HHS approach was criticized by those who expected one national standard for essential benefits. Some Democratic members of Congress wrote to HHS saying that achieving a national approach was their intention when drafting the law.

Consumer advocates and some provider groups also had sought a national standard to reduce variation from state to state and to ensure a sufficient minimum benefit package. They complained that HHS's approach does not address the fact that many health plans have inadequate benefits. More than 2,400 doctors, nurses, and health advocates signed a letter to HHS dated December 1, 2011, saying that the department's approach would "enshrine these skimpy plans as the new standard."

POLICY PROCESS CRITICIZED: HHS did not follow its normal processes in issuing its essential health benefits "guidance," or policy interpretation. Normally, HHS would have issued a proposed rule, solicited public comment, and then taken account of received comments in crafting a final regulation. In this case, HHS released a "bulletin" in December 2011 and did not make the comments it received on the bulletin public. In November 2012 HHS issued a proposed rule that largely mirrored the policies described in the bulletin and finalized the rule in February 2013, with modest changes after a 30-day comment period. Although HHS says it acted legally, this atypical approach has been widely criticized.

BENCHMARK PLANS

According to the information HHS has released about the benchmark plan in each state, about half the states selected a plan and half defaulted to the largest small-group product. In 45 states and the District of Columbia, the benchmark is one of the products in the small-group market. In all but four of those states, it is the largest product. Two states chose a state employee plan, and three chose the largest commercial HMO.

To include all categories of essential benefits, most states supplement their benchmark plan. All states but Utah supplement their benchmark plan with pediatric services, ei-

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ther vision or oral care, or both. In addition, Arkansas and Alaska supplement their benchmark plans with mental health and substance disorder services. In 30 states, the benchmark includes habilitative services. Nine of the remaining 21 states define habilitative services, while 12 leave that definition up to the plan.

WHAT'S NEXT?

Now that the states have selected benchmark plans, insurers in the small-group and individual market are assessing whether their plans contain the essential health benefits. One analysis concluded that less than two percent of existing plans on the individual market include all the required benefits, and that existing individual plans cover only about 74 percent of required benefits on average.

Many insurers and employers have voiced concern that the essential health benefit package is more generous than existing employer-sponsored coverage and therefore will be more expensive. America's Health Insurance Plans, a national association representing the health insurance industry, predicts that premiums in the individual market could increase by as much as one-third in some states. As insurers incorporate required benefits into their plan packages for 2014, more will be known about the impact on premiums and affordability.■

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