



Health Policy Brief

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Essential Health Benefits. States will determine the minimum set of benefits to be included in individual and small group insurance plans. What lies ahead?

WHAT'S THE ISSUE?

The Affordable Care Act of 2010 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) has 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 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.

BALANCING ACT: Determining which benefits 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” coverage by

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Essential health benefits

Insurance plans for individuals and small businesses must provide at least 10 categories of “essential health benefits.”

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.

In December 2011 HHS issued a bulletin describing the approach it will use to determine essential health benefits. 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 plan options 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. Insurers are not required 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.

According to HHS, most of the potential benchmark plans that it has identified cover similar services in nearly all of the 10 required categories. The categories least likely to be covered in potential benchmark plans are pediatric oral services; pediatric vision services; and “habilitative” services to assist people with disabilities to learn new skills and functions, such as helping autistic children improve language skills. If a state chooses a benchmark plan that does not cover services in a required

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

62%

Lack maternity coverage

HHS estimates that 62 percent of insurance plans in the individual market do not provide maternity benefits.

“Observers now expect most states to select a small group plan as the benchmark.”

category, the state must supplement the essential benefits package by adopting benefits from any other possible benchmark plan.

Observers now expect most states to select a small group plan as the benchmark, because such plans are already approved by state insurance commissioners and are therefore most familiar to regulators.

The federal government’s decision on the approach to essential health benefits has been generally well received by states, health plans, and the business community. They like the fact that the essential health benefits package will be drawn from insurance policies that are already offered and that are popular in each state, minimizing the need for insurers to make changes and allowing small employers to continue coverage that is similar to what they already offer.

Officials from several states have praised the HHS approach as being the best choice, 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.

CRITICISMS: In contrast, the HHS approach has been criticized by those who were expecting a single 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, meanwhile, had sought a national standard to reduce variation from state to state and to ensure that the plans were of sufficient quality.

Some have complained that HHS’s approach will now not address the fact that many health plans have inadequate benefits. For example, more than 2,400 doctors, nurses, and health advocates signed a letter to HHS dated December 1, 2011, saying that the approach the department had selected would “enshrine these skimpy plans as the new standard.”

Another criticism was that HHS did not follow its normal processes in issuing its essential health benefits “guidance,” or policy interpretation. Normally, the department would have issued a proposed rule and solicited public comment; it then would have taken that comment into account in crafting a final regulation. In this case, HHS released a “bulletin” and not a proposed rule for comment, and, in turn, did not make the comments it re-

ceived publicly available. Although HHS says it acted legally, its atypical approach has been widely criticized.

REMAINING ISSUES

States now face the need to move forward quickly, as the first open enrollment period for coverage sold through new health insurance exchanges will begin in October 2013. Yet as states proceed to select their essential health benefits benchmark plans, other key issues and questions remain.

- **The role of state-mandated benefits.** An unusual provision of the Affordable Care Act pertaining to states’ benefit mandates may affect some states as they select their benchmark essential health benefits packages. All states have such benefit mandates, from a low of 13 mandates in Iowa to a high of 69 in Rhode Island. Examples range 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.

Most of these benefit mandates are typically included in the plans from which states will be able to select as the benchmark plan. However, some states apply mandates only to plans offered in certain markets and may not require coverage by all possible benchmark plans. For example, a benefit mandate may apply only to individual insurance or to HMO products sold in a state.

According to the Affordable Care Act, if a state requires benefits that exceed those included in the essential health benefits package, then the state has to directly pay the cost of these additional mandates. Under the benchmark approach adopted by HHS, a state can avoid having to pay any extra cost by choosing as its benchmark plan one that includes all benefits mandated for the small group and individual markets in the state.

The law does not specify, and HHS guidance has not clarified, how this money will be paid or where it will go. One analysis by the National Institute for Health Care Reform, a nonprofit institute linked to the Center for Studying Health System Change, has estimated that the state of Maryland may end up having to pay for five state benefit mandates not likely to be included in a benchmark plan. The institute estimates that the cost to Maryland could be between \$10 million and \$80 million

annually. It is not clear how many other states will be affected.

- **Benefit designs and limits.** Another issue is how much flexibility insurance plans will have to vary the scope and duration of covered services and still meet the requirements of providing essential health benefits. Although plans may no longer impose annual or lifetime dollar limits, HHS will allow them to impose limits on the scope and duration of benefits. For example, plans could limit the number of outpatient mental health therapy visits annually. Some advocacy groups worry that having this flexibility will enable insurers to develop plans that discourage enrollment of sicker beneficiaries.

- **Definition of “medical necessity.”** Medical necessity is a standard that insurers use to describe benefits that will be covered by their plans. Insurers want to continue to apply their own definitions of medical necessity, particularly as these relate to coverage of “habilita-

tive services,” which are often not well defined and currently aren’t often covered by insurers. Patient advocates, however, want HHS to develop a federal definition of medical necessity that will help to clarify which of these services should be covered as essential health benefits.

WHAT’S NEXT?

Many observers expect that the policy focus will shift now to the states, as insurers, providers, and advocates attempt to influence selection of benchmark plans. However, some important procedural and policy questions remain unanswered at the federal level, including what process HHS will use to evaluate whether the state benchmarks meet all requirements and how the states must value the cost of benefit mandates that exceed the essential benefits package.

HHS has not specified a timetable for releasing additional guidance. ■

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RESOURCES

Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, “[Essential Health Benefits Bulletin](#),” December 16, 2011.

Hall, Mark A., “[Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms](#),” *Health Affairs* 31, no. 2 (2012): 316–23.

Institute of Medicine, “[Essential Health Benefits: Balancing Coverage and Cost](#),” National Academies Press, October 6, 2011.

Levey, Noam A., “[Passing the Buck—or Empowering States? Who Will Define Essential Health Benefits](#),” *Health Affairs* 31, no. 4 (2012): 663–6.

White, Chapin and Amanda E. Lechner, “[State Benefit Mandates and National Health Reform](#),” National Institute for Health Care Reform, February 2012.