Essential Health Benefits: Issues to Watch

Essential Health Benefits (EHB) refer to a package of health services of ten benefit areas that must be included in all individual and small group health insurance plans. EHB present an opportunity to protect consumers and ensure better access to care.

Earlier this year, the Center for Consumer Information and Insurance Oversight (CCIIO) outlined a process for states to choose their own state-specific EHB packages. States were given the option of selecting their EHB benchmark plan from one of ten options – one of the three largest small-group plans, one of the three largest plans for federal employees, one of the three largest state-employee plans, or the largest HMO plan in the state. If a state did not select a plan, the state's EHB plan defaulted to the largest small-group plan.

This summer and early fall, state insurance departments (in states retaining plan management functions) or CCIIO approved health plans to meet Affordable Care Act (ACA) rules. As part of this review, state DOIs and CCIIO were supposed to ensure that in small group and individual markets, plans cover all ten benefit areas of the EHB.

Because a number of these benefits are newly offered as part of individual and small group plans, it is likely that challenges may emerge in the first year. For instance, despite the regulatory oversight of DOIs, some plans may not adequately cover all ten categories of benefits.

Consumer advocates can use this opportunity to review and monitor health benefits to ensure compliance with consumer protections. While the ACA lays out opportunities to ensure equitable coverage and access, advocates can ensure these benefits are implemented and work to identify gaps for future advocacy to fill in.

This issue brief highlights key areas that advocates may want to monitor regarding EHB. Community Catalyst suggests choosing one or two issues of focus that are most strategic and important to your state and coalition's work.

1. **EHB allows "substituting" certain benefits:** As long as health plans are "substantially equal" to the EHB benchmark, HHS rules allow insurers to make alterations to specific coverage and design options within, but not across, each of the 10 benefit areas. Insurers are allowed to swap certain services as long as they are of equivalent actuarial value (the amount of health care costs covered by an insurer for the average enrollee). For example, an insurer may cover only a certain class of physical therapy visits. Or, they may increase coverage for certain types of prescription drugs while decreasing coverage for others. In this manner, substitution could be a way insurers attract a healthier, less costly, and less medically complex population. States have the option to adopt more stringent standards that limit or prohibit this type of substitution.

Issues to watch with substitution:

- **Complicated Plan Selection:** Substitutions create variation in health plans which can make it harder for consumers to make 'apples-to-apples' comparisons, complicating the plan selection process. For example, it is difficult for a consumer to decipher differences between two plans' physical therapy coverage. Substitutions reduce transparency.
- **Cherry-picking:** Substitutions may also allow insurance companies to enroll healthier consumers by substituting out services that sicker populations rely on. For example, an insurer may substitute out services needed by individuals living with chronic conditions and replace them with services that are of the same actuarial value but are targeted to younger, healthier individuals. Subsequently, sicker patients may not choose this plan and the insurance company ends up with a healthier enrollee pool.
- **Compliance and Enforcement:** Substitutions based on actuarial value are new and confusing for both policymakers and consumers, and any substitution should be closely monitored to ensure compliance with standards and adequate benefits.

2. **Pediatric Dental Services:** EHB plans must either include pediatric dental services or supplement the benefit to comply with coverage standards. However, if a stand-alone dental plan is offered in the Marketplace, qualified health plans (QHPs) in the Marketplace do not have to offer dental benefits and families are not mandated to purchase coverage. This makes it possible for families buying plans in the Marketplace to bypass getting pediatric dental coverage. Because this is a new benefit for nearly all plans, and one that could substantially impact children's access to dental care, it is an important area to monitor.

Issues to watch with pediatric dental:

- **Affordability:** For families who purchase stand-alone dental packages (because their health plan does not include dental), financial assistance for premiums first covers medical insurance. Any remaining assistance is then directed toward dental insurance. This means that families may have to purchase cheaper coverage in order to afford both dental and medical insurance. In addition, cost-sharing for stand-alone dental plans has a limit up to $700 per child and $1,400 for families with two or more children, on top of cost sharing for medical insurance.[1] Dental cost-sharing can considerably raise a family's out-of-pocket expenses.
- **Access:** Families are not required to purchase dental coverage when it is offered separately in the Marketplace. This may create confusion or discourage families with cost concerns from signing up for coverage.
- **Consumer Protections:** Stand-alone dental plans are exempt from a number of important consumer protections in the ACA, including cost-sharing limits.

[1] A recent rule reduces the cost-sharing to $300 per child and $400 per family for stand-alone dental plans. Comments are due at the end of 2013. It remains uncertain if this change will be for only Federally Facilitated Marketplaces and/or all Marketplaces.

- **Differences Inside vs. Outside the Marketplace:** In any individual or small group health plan outside of the Marketplace, dental benefits must either be embedded in health plans or plans must have "reasonable assurance" that enrollees with children have purchased stand-alone pediatric dental coverage. This differs from inside the Marketplace, where there are no assurances that families enroll in dental coverage.

See this brief for more information on pediatric dental coverage under the ACA.

3. **Mental Health and Substance Use Disorders:** Coverage for services to treat mental health and substance use disorders is now included as one of the ten categories of EHB. This benefit is paired with the 2008 Mental Health Parity law that requires health insurers to cover mental health and substance use disorder treatment to the same extent as other medical treatments. These are new benefits for many plans, and some services may not be adequately covered by current state benchmarks. Therefore, it will be important to monitor plans for such adequate benefits.

   Issues to watch with mental health and SUD benefits:

   - **Adequacy of Benefits:** Some areas of mental health and substance abuse services may not be adequately covered by state benchmark plans. The Coalition for Whole Health developed this checklist tool to determine whether states meet guidelines for adequate mental health and substance use disorder coverage. It will be critical to monitor these services as consumers access benefits over the next few months.

4. **Non-discrimination:** EHB rules require that benefits are provided without discrimination based on health condition, race, color, national origin, age, disability, sex, sexual orientation, or gender identity. However, there is currently no established way for determining discrimination in a health benefit package, making it difficult to identify such practices. Therefore, monitoring is necessary to ensure vulnerable consumers have adequate access to benefits. To assist with this, some states have developed bulletins to clarify non-discrimination in health plans.

   Issues to watch in non-discrimination:

   - **Coverage for services for people with disabilities:** Health plans that do not cover certain services that disabled persons utilize to a greater extent than others, such as physical therapies, may be in violation of the non-discrimination laws of the ACA.
   - **Coverage for women's health and maternity services:** Women's health needs are unique from other populations. Ensuring that women can access the health services they need are important issues to watch in non-discrimination.
   - **Coverage for services for transgender people:** To meet non-discrimination standards, EHB services covered for a non-transgender consumer must also be covered for a transgender consumer. These services have been determined medically necessary by the American Medical Association and American Psychological Association, among others. Thus far, insurance commissioners in five states (OR, CO, CA, VT, DE) and Washington D.C. have issued bulletins that interpret non-

discrimination rules to prohibit insurers from discriminating against transgender consumers. For more information, see this issue brief from the Center for American Progress.

5. **Habilitative Services:** One of the 10 EHB benefit categories, habilitative services are occupational, physical, or speech therapies that help individuals gain, maintain, or improve daily functioning. This category is distinct from rehabilitative services because it helps people develop capacities for the first time, rather than restore functioning.

   Issues to watch in habilitative services:

   - **Defining Habilitative Care:** The ACA gives broad regulatory control to states on habilitative care, including whether a state wants to define the category, as five states thus far have done. If a state does not define habilitative services, it is left up to insurers.
   - **Exclusion from Coverage:** Without standardized definitions, insurers can decide to only cover certain service areas, based on the cost of the services or the health of people who access these services. For example, health plans can cap the number of physical therapy visits or limit prosthetic limb coverage to one per lifetime. Limitations could result in a lack of needed coverage for populations that rely on these services most. Advocates should closely monitor how habilitative services' coverage unfolds in their states and be wary that the services covered may be inadequate.

6. **Women's Health:** Women's health needs are an important area to watch with respect to EHB to ensure adequate access to medical services. Women statistically earn less than their male counterparts, are less likely to have employer-based coverage, and are disproportionately affected by certain conditions. Many basic benefits for women, like maternity and contraceptive services, have historically not been covered by many health plans, especially in the individual market.

   Issues to watch in women's health:

   - **Preventive Services:** The ACA covers preventive services with no cost-sharing. EHB plans should include the range and scope of health services women need, including contraception and testing. Insurers may not cover all types of services or brands of contraceptives. Advocates should monitor the impact of what is and is not available to ensure that women are able to gain access to what medical services or prescriptions are appropriate for them. This checklist, developed by the Kaiser Family Foundation, helps monitor covered services for women.
   - **Maternity Care:** EHB covers a wide range of maternity services. But given the importance of maternity care to infant health outcomes, quality and access to appropriate services are vitally important. Advocates should monitor what services (i.e., pre-/inter-conception, prenatal, delivery, and postpartum care) are covered and what is missing.