An introduction to "essential health benefits"

Ohio's role in determining services covered by insurance post-2014

Background

The Patient Protection and Affordable Care Act (ACA) requires that most small group and individual health insurance plans offer a comprehensive package of covered items and services known as "essential health benefits" (EHB) beginning January 1, 2014. This provision pertains to plans offered both inside and outside a federal or state insurance exchange, with the exception of "grandfathered" plans. Grandfathered plans are those plans established prior to the passage of the ACA on March 23, 2010 which have not made substantial modifications[i] to covered services. The intent of the EHB provision is to assure consumers and small businesses that when they purchase a health plan, they can be certain that it will cover a comprehensive set of health services.

10 statutory essential benefits categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse 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

In December 2011, the Department of Health and Human Services (HHS) issued a Bulletin signaling its intent to allow states to determine individually the benchmark set of essential health benefits for plans sold in their state. While states are required to make a decision on EHB by the 3rd quarter of 2012, and HHS has stated that they do "intend to pursue comprehensive rulemaking on essential health benefits in the future," as of publication of this brief, the final rules have not been released.[ii]

How does the ACA define essential health benefits?

The ACA charges the HHS Secretary with defining what constitutes "essential health benefits." It further states that the scope of the EHB should be equal to the scope of benefits provided under a "typical" employer plan.[iii] However, other than identifying ten broad categories of items (see box above) and services that essential health benefits must include, the law provides no definition for "typical" health plan; nor does the ACA offer specific definitions or parameters for health care benefits (e.g. frequency or number of visits) within each of these categories.

How did HHS assess which benefits are covered by a "typical" employer health plan?

In assessing which benefits are typically covered, HHS gathered benefit information on large employer plans, small employer plans, and plans offered to public employees. HHS relied on a range of sources for its assessment including a survey and report on employer plans conducted by the Department of Labor (DOL); recommendations on the process for defining and updating EHB from the Institute of Medicine (IOM); employer surveys conducted by Mercer and Kaiser Family Foundation/Health Research & Educational Trust (KFF/HRET); and input from the public and other interested stakeholders.

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How do the 10 categories of essential health benefits identified by the ACA compare to services currently covered by "typical" individual and small group plans?

HHS found little variation in covered services across small group insurance markets and plans. Most of the small group plans cover health care services in almost all of the 10 statutory EHB categories. Consistently covered benefits include physician and specialist office visits, inpatient and outpatient surgery, hospitalization, organ transplants, emergency services, and maternity care.

While inpatient and outpatient behavioral health, mental health and substance abuse are generally covered by plans in the small group market, there are often limits on the number or frequency of visits. Similarly, while most small group plans offer rehabilitative services such as physical, occupational, and speech therapy as covered benefits, there are often visit limits. Coverage of these therapies for habilitative purposes (i.e. to learn new skills or functions) may be included under the rehabilitation benefit, but plans generally do not identify habilitative services as a distinct group of covered services.

In contrast to the small group market, plans offered on the Individual market often offer little or no coverage in the areas of maternity, substance abuse, mental health, and prescription drugs. Therefore, those who buy coverage in the individual market likely will gain access to a more robust benefit package in 2014.

After reviewing the national health plan benefits, what did HHS conclude with regard to defining EHB?

First and foremost, as stressed by the IOM in its report to HHS, *Essential Health Benefits: Balancing Coverage and Cost*,[iv] HHS decided that the EHB package must balance the need for comprehensiveness of covered services with the need to keep plans affordable for consumers and small businesses purchasing coverage either outside or inside an exchange. Further, as required by the statute, the EHB package must reflect typical employer health plan benefits, must include the 10 categories of services identified in the ACA, and must provide a balance among the categories. To ensure that the EHB accounts for diverse health needs across populations and states, HHS reserved for states a prominent role in defining EHB. In addition, HHS recognized and adopted the IOM's recommended process by which EHB benefits could be updated to account for medical advances, changes in costs, or newly-identified gaps in coverage.

What is the State's role with regard to EHB?

In an HHS Bulletin issued in December 2011, HHS proposed that States be allowed to establish their own individual EHB design by selecting a benchmark plan that would serve as a reference plan. The reference plan would reflect both the scope of services and limits offered by a "typical employer plan" in that state.[v] The benefits and services included in this selected benchmark plan would become the state's essential health benefits package. Future HHS guidance is expected to address cost sharing rules for health plans such as deductibles, copayments and coinsurance.

> ***"Our approach will protect consumers and give states the flexibility to design coverage options that meet their unique needs"***
> — HHS Secretary Kathleen Sebelius

To ensure a "consistent and consumer-oriented set of options," HHS specified the list of benchmark alternatives from which a state could choose:

1. The largest plan by enrollment in any of the three largest small group insurance products
2. Any of the largest three State employee health benefit plans by enrollment
3. Any of the largest three national Federal Employee Health Benefit (FEHBP) plan options by enrollment
4. The largest insured commercial non-Medicaid HMO operating in the state

States are directed to identify their benchmark by 3rd quarter of 2012 using enrollment data from 1st quarter 2012. If a State does not choose a benchmark, the largest small group plan will serve as the

default. In the future, states will have to select an EHB benchmark plan in the third quarter two years prior to the coverage year, based on enrollment from the first quarter of that year.

In order to be certified and offered in exchanges, insurance policies will be required to offer benefits "substantially equal" to the benchmark plan selected by the state. If a chosen benchmark plan is missing one or more of the ten federal EHB categories of benefits, states must supplement the plan from one of the other benchmark alternatives. Insurers are permitted to adjust benefits, including both the specific services covered and any quantitative limits, as long as they cover all 10 statutory EHB categories and the coverage has the same value as the benchmark plan.

Since the ACA specifically forbids annual or lifetime dollar limits on coverage, any benefit (including a state-mandated benefit) included within the benchmark plan that has a dollar limit would be incorporated into the EHB without the dollar limit.

This initial benchmark plan will apply to benefit years 2014 and 2015. HHS intends to revisit this approach beginning in 2016.

Exhibit 1: Ohio mandated benefits compared to ACA essential benefits

Benefit description	ACA essential
Alcoholism/Substance Abuse	Yes
Breast Reconstruction	Yes
Cervical Cancer/HPV Screening	Yes
Cancer Clinical Trial	Yes
Emergency Service	Yes
Mammography	Yes
Maternity Minimum Stay	Yes
Mental Health (General)	Yes
Mental Health Parity	Yes
Newborn Hearing Screening	Yes
Off Label Drug Use +	Unknown
Well Child Care	Yes
Outpatient Kidney Dialysis	Yes

+ Subsection 3923.60 of the Ohio Revised Code states that off-label drugs must be covered "provided that the drug has been recognized as safe and effective for treatment of that indication in one or more standard medical reference compendia…or in medical literature…." The extent to which off-label drug usage is included in the essential benefit package is not yet clear.

Does the benchmark plan need to include all state-mandated benefits?

The benchmark plan must be compared to state mandated benefits enacted before December 31, 2011. If the benchmark plan does not include all state-mandated benefits (regardless of whether the mandate applies to the small group market, individual market, or both), then the state must defray the cost of that mandated coverage for citizens receiving subsidized insurance plans.

How do the ACA EHB standards align with Ohio's existing mandated benefits?

Using federal exchange planning grant funds, the Ohio Department of Insurance contracted with Milliman, Inc. to research design and implementation issues related to an insurance exchange in Ohio, including the impact of EHB. As part of its analysis, Milliman compared Ohio's current mandated benefits with the ACA essential benefits categories (Exhibit 1).

How was this approach received by stakeholders?

States and insurers were generally pleased that HHS acknowledged and allowed for local variation in setting EHB. Others, particularly consumer advocates, were disappointed that a national standard set of core benefits was not established to ensure comprehensive and affordable coverage to all. Some experts have speculated that HHS's current approach is an intermediate step in an evolution toward a single national set of EHB – a step that would force a thoughtful examination of mandated benefits which currently vary greatly state to state.

What was the process for determining each state's benchmark plan options?

On June 1, 2012, HHS released a proposed rule on data collection for health plans related to establishing the state benchmark EHB.[vi] It directed insurers offering the three largest small group products to provide HHS with medical plan data and standalone dental data, if applicable. The rule permitted insurers to use their own enrollment numbers as of March 31, 2012 to determine the largest plan within a product. An accompanying notice provided detailed exhibits for insurers identifying the required data elements (e.g. treatment limitations, step therapy requirements for prescription drugs).[vii] The same notice included a template for the state to identify existing state mandates.

For which benefit categories did HHS provide further guidance with respect to defining EHB?

For purposes of EHB, HHS requires coverage for inpatient and outpatient behavioral health, mental health and substance abuse services to be consistent with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Further, HHS proposes that habilitative services for EHB be offered at parity with rehabilitation services. With respect to establishing EHB for pediatric dental and vision care, HHS directs states to consider adopting the benefits provided by the Federal Employees Dental and Vision Insurance Program (FEDVIP) with the highest national enrollment or by the state's separate Children's Health Insurance Program (CHIP).

What are Ohio's benchmark plan alternatives?

Based on data submitted to HHS, the Center for Consumer Information and Insurance Oversight (CCIIO) under CMS released a list on July 3, 2012, identifying the largest three small group products by state and the largest three national FEHBP plans.[viii] According to the report, Ohio's largest three small group products in descending order are as follows:

1. Anthem PPO (ID #29276OH050)
2. Medical Mutual of Ohio SuperMed (ID #80627OH005)
3. Anthem Lumenos (ID #29276OH051)

The report identified the largest three national FEHBP plan options as the following PPO plans:

1. Blue Cross Blue Shield Standard Option
2. Blue Cross Blue Shield Basic Option
3. Government Employees Health Association Standard Option

The State employee benefit plans in Ohio are self-funded and administered by either United HealthCare or Medical Mutual of Ohio, depending on the employee's home zip code.

As of the publication of this brief, there has been no listing by state of the largest "insured commercial non-Medicaid HMOs." Some states have issued public callouts to the HMOs operating in the state while others have used existing data housed in state government agencies.

If Ohio does not make a selection, which plan will serve as the default benchmark?

If Ohio does not make a selection, the largest small group plan, the Anthem PPO, will serve as the default. Exhibit 2 provides a comparison of benefits covered by the Anthem PPO versus the State and Federal employee health plans. Similar comparisons have been done by other states, either using external consultants and/or government agency resources. The National Academy for State Health Policy created a section on its State Refor(u)m website (www.statereforum.org) to aggregate resources and documents related to EHB.[ix]

Conclusion

Ohio policymakers have an opportunity to identify Ohio's benchmark for Essential Health Benefits from the specified alternatives, with a third quarter 2012 deadline. If Ohio policymakers do not identify the benchmark, the default benchmark will be the largest small group plan, the Anthem PPO. In considering what this means for Ohioans purchasing coverage in the small group and individual markets, Ohio's policymakers and other stakeholders must balance the desire for consistency and comprehensiveness of benefits with potential increased cost in covering these benefits. Additional analysis may be necessary when the final rules and other related guidance to Essential Health Benefits are released by the federal government.

Notes

i www.healthreform.gov/about/grandfathering.html
ii www.ofr.gov/OFRUpload/OFRData/2012-13489_PI.pdf
iii PPACA §1302
iv www.iom.edu/reports/2011/essential-health-benefits-balancing-coverage-and-cost.aspx
v cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
vi www.ofr.gov/OFRUpload/OFRData/2012-13489_PI.pdf
vii www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1247405.html
viii cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.pdf
ix www.statereforum.org/state-progress-on-essential-health-benefits

Exhibit 2: Sample Comparison for EHB

Benefits provided by potential benchmark major medical plans
Grouped in the 10 categories of EHB required by the ACA[1]

Benefits[2]	State Employee Health Plan	Federal Health Employee Benefits Program (FHEBP) Blue Cross-Blue Shield Standard Option	Anthem Small Group preferred provider organization (PPO)
1. Ambulatory patient services			
Primary care to treat illness/injury	✔ (100% after $20 co-pay)	✔	✔
Specialist visits	✔ (100% after $20 co-pay)	✔	✔
Outpatient surgery	✔	✔	✔
Chiropractic (therapeutic, adjustive, manipulative)	✔	✔ (max for manipulative [osteo & chiro]: 12 visits/yr)	✔
Chemotherapy services	✔	✔	✔
Radiation therapy	✔	✔	
Anesthesia	✔	✔	✔
Home health care	✔ (greater of 100 visits or 180 days/yr)	✔ (max: 25 2-hour visits/yr)	✔ (max: 90 visits/yr)
Infertility	✔ (80% after $20 co-pay)		
Access to clinical trials	✔	✔	
Hospice	✔	✔	✔
Dental Injury	✔	✔	✔
Temporomandibular joint (TMJ) services	✔	✔	
2. Emergency services			
Emergency room care	✔ ($75 co-pay)	✔	✔
Ambulance service	✔	✔	✔
Urgent care centers/facilities	✔ (80% after $20 co-pay)	✔	✔
3. Hospitalization			
Inpatient medical and surgical care	✔	✔	✔
Bariatric surgery	✔	✔ (criteria must be met)	
Organ & tissue transplants	✔	✔ (organs specified)	✔
4. Maternity and newborn care			
Pre- & postnatal care	✔ (100% after copay on first visit)	✔	✔
Delivery & inpatient maternity services	✔	✔	✔
Newborn child coverage	✔	✔	✔
5. Mental health and substance abuse treatment			
Benefits for treating alcoholism & drug dependency	✔	✔	✔
Benefits for mental health services	✔	✔	✔
Inpatient services	✔	✔	✔
Outpatient services	✔	✔	✔
6. Prescription drugs			
Retail	✔	✔	✔
Mail service (home delivery)	✔	✔	✔

Benefits[2]	State Employee Health Plan	FHBP BCBS Standard Option	Anthem Small Group PPO
7. Rehabilitative and habilitative services and devices			
Physical, speech & occupational therapy	✔	✔ (combined max: 75 visits/year)	✔ (20 visits/yr for each)
Cardiac rehabilitation	✔	✔	✔ (36 visits/yr)
Pulmonary rehabilitation	✔	✔	✔ (20 visits/yr)
Durable medical equipment	✔	✔	✔ (max: $4,000/yr)
Prosthetics - arm or leg	✔	✔	✔ (max: $4,000/yr)
Skilled nursing & rehab	✔ (80% for first 180 days/yr and 60% after)	✔ (30 days/yr max on on Medicare Part A)	✔ (max: 90 days/yr)
8. Laboratory services			
Lab tests & xray services	✔	✔	✔
Imaging/diagnostics (e.g., MRI, CT scan, PET scan)	✔	✔	✔
9. Preventive and wellness services and chronic disease management			
Preventive care	✔	✔	✔
Immunizations	✔	✔	✔
Colorectal cancer screening	✔ (every 10 years after age 50)	✔	✔
Screening mammography	✔ (100% for first year age 35+; 80% younger than 35)	✔	✔
Eye care & 1 routine eye exam per 2 years, unless over 65 or diabetic	✔ (100% after copay)	✔ (100% related to medical condition)	✔
Audiology/hearing tests	✔	✔ (related to illness/ injury)	✔
Nutritional counseling	✔ (100% 2 visits/year; 80% unlimited for diabetes & obesity)	✔	
Allergy testing & injections	✔	✔	✔
Diabetes - medically necessary equip. & supplies; education	✔ (100% if enrolled in disease management)	✔	
Screening Pap tests	✔	✔	✔
Annual gynecological exam	✔	✔	✔
Annual prostrate cancer screening for men 50-72 yrs.	✔ (100% age 40+; 80% under 40)	✔	✔
10. Pediatric services, including oral and vision care			
Preventive care — physician services	✔	✔	✔
Immunizations	✔	✔	✔
1 routine eye exam per year, to age 19	✔	✔	
Routine hearing exams, to age 19	✔	✔	✔
Dental - diagnostic & preventive	✔	✔	
Dental - basic	✔	✔	
Dental - major	✔	✔ (certain procedures when criteria met)	
Hearing aids to age 18	✔	✔ (certain procedures when criteria met)	

1. Benefits were grouped within the Federally directed 10 Essential Health Benefit categories using products from Maine and Alabama as guides.
2. Summary Benefit Descriptions and employee marketing materials were interpreted to indicate coverage by category. Any blanks indicate no information found. Issuer's Certificates of Coverage should be used in formal Benchmark Comparison exercise.