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POLICY PAGE

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Essential Health Benefits in Texas

On December 16, 2011, the U.S. Department of Health and Human Services (HHS) released a bulletin describing its proposed approach to defining the "essential health benefits" under the Affordable Care Act (ACA, commonly referred to as national health reform). Starting in 2014, the essential health benefits (EHB) will serve as a floor for the package of health care services that must be covered in many health insurance policies. The ACA establishes some parameters for EHB, but HHS' recent bulletin leaves it up to the states to define EHB within the federal framework. HHS is accepting public comment on its EHB approach through January 31, 2012, via EssentialHealthBenefits@cms.hhs.gov. This *Policy Page* explains EHB, reviews Texas' options, and discusses what we still do not know about minimum standards for coverage in 2014.

What are the Essential Health Benefits?

Requirements in the ACA

The ACA establishes EHB as a minimum floor for medical benefits that must be included in many types of health insurance policies. The law says that EHB must include services in at least the following ten categories of benefits:

- 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, and
- pediatric services, including oral and vision care.

The ACA also requires EHB to:

- be equal in scope to benefits provided under a typical employer plan,
- be balanced among the ten categories listed above,
- not have a benefit design that discriminates against individuals because of their age, disability or expected length of life,
- take into account the health care needs of diverse populations, and
- be reviewed and updated periodically by HHS.

Finally, the ACA requires states to cover the cost of any state mandated benefits that exceed the EHB in all plans certified to be sold within the health insurance exchange starting in 2014.[1]

Essential Health Benefits Provide an Important Protection

The floor on covered services established by the EHB is a critical step in ensuring that Americans have access to coverage sufficient to help them stay well and get treatment when sick. In combination with other ACA provisions, including a plan's cost-sharing features and sliding scale premium and cost-sharing subsidies for low- and moderate-income individuals, EHB will help ensure that after 2014, medical problems will no longer be the primary cause of U.S. personal bankruptcies.

People who buy their coverage in the individual market (directly from an insurer, as opposed to coverage through an employer) will benefit the most from EHB because individual market policies today are generally the least comprehensive. For example, coverage for maternity services in the individual market is virtually nonexistent today in Texas. Individual market plans and some small employer plans today may also lack or have limited coverage for mental health, substance abuse, behavioral health, prescription drugs, habilitative care, and pediatric dental and vision care—all of which must be included in the EHB.

The EHB will also provide greater uniformity among plans—though insurers may offer benefits in addition to EHB, and as discussed below, federal guidance may even allow insurers to vary EHB somewhat. Ideally, establishing EHB will allow us to rest assured that when shopping for coverage, the baseline benefits and limits will not vary, letting us to focus on comparing plans' premiums, cost-sharing, provider networks, etc.

Interaction with Cost Sharing

The ACA separately addresses a plan's covered services (through EHB) and the plan's cost-sharing features (out-of-pocket costs like deductibles, copayments, and coinsurance). A plan's cost sharing will determine what "metal level" tier it falls in: platinum, gold, silver, or bronze. A platinum plan will cover 90 percent of the cost of covered services on average, with the enrollee paying 10 percent on average in cost sharing. Gold plans cover 80 percent, silver covers 70 percent and bronze covers 60 percent, on average. Health insurance policies in different metal levels can thus cover the exact same EHB, but still vary dramatically in their premiums and what a person would have to pay out-of-pocket if they got sick.

HHS' EHB bulletin says the agency will release guidance on determining a plan's metal level for cost sharing soon. Until that is released, we will not have the full picture of how comprehensive coverage will be in 2014. For example, we know from the EHB that rehabilitation is covered, and once Texas chooses an EHB benchmark (more on that below), we will know what type of limits can be placed on rehab (for example, no more than 25 outpatient visits per year). But at this point, we do not know if a plan would be allowed to structure its benefits, for example, so that rehabilitation (or any other benefit) is subject to higher copayments or coinsurance that other covered services. In other words, if consumer out-of-pocket costs for an essential benefit are too high, that medical care may be too expensive to access, despite the care being a required covered benefit.

Plans that Must Include EHB

Starting in 2014, plans sold within the exchange, as well as individual market and small employer plans sold outside of the exchange must include EHB. EHB must also be covered by Medicaid benchmark plans (plans that may be offered to the ACA Medicaid expansion population) and any Basic Health Plans (in states that choose this option). The EHB bulletin indicates that HHS intends to issue future guidance on implementing EHB within Medicaid.

Self-insured plans (coverage typical of large employers), are not required to cover EHB; however self-insured plans tend to have comprehensive benefits that cover much of the EHB.

States Given Flexibility to Define EHB

The recent bulletin from HHS does not establish a uniform, national EHB standard as many advocates had hoped. Rather, HHS proposes to allow each state to choose an existing benchmark plan that will define the EHB within the state. As described in the bulletin, the "selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a 'typical employer plan' in that State."

HHS proposes to allow states to choose its EHB benchmark from the following benchmark options:

- Any of the three largest plans by enrollment in the small employer market,
- Any of the three largest state employee health plans by enrollment,
- Any of the three largest federal employee health benefit plan options by enrollment, or
- The largest insured commercial non-Medicaid HMO plan in the state.

States will use enrollment data from the first quarter of 2012 to identify benchmark options for 2014, and states must select their EHB benchmarks for 2014 in the third quarter of 2012. If a state does not exercise its option to select a benchmark, HHS proposes that the state's benchmark will default to the largest plan by enrollment in the small employer market.

HHS' bulletin indicates that the state benchmark structure would be used in at least 2014 and 2015, and HHS would evaluate the benchmark process for 2016 and beyond.

Coverage within Benchmark Options

Unfortunately, we do not know today exactly which ten plans Texas will be able to choose from. The Texas Department of Insurance (TDI) does not collect information on enrollment by plan, so it cannot identify the three largest small employer plans and the largest HMO plan at this point. HHS may have that data as part of the information they collect to display on www.healthcare.gov, but if it does, it did not release it with the bulletin. Information for the state employee plans would need to be obtained from the Employees Retirement System of Texas (ERS) and the federal employee plans from the Office of Personnel Management (OPM). Many consumer and patient advocacy organizations have requested that HHS compile and release the coverage information for each state's benchmark options so that advocates can fully evaluate the possible benchmarks before commenting on HHS' bulletin.

Analyses cited in the HHS bulletin show that in general, health insurance plans in the small employer market, state employee plans, and federal employee plans do not differ significantly in the services they cover. Rather, these plans vary primarily in their cost-sharing features. According to HHS' bulletin, plans in these markets consistently cover: "physician and specialist office visits, inpatient and outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations."

Most of the ten categories of benefits the ACA lists for inclusion in the EHB are generally standard coverage in group health insurance policies today; however, some benefits like habilitative services,[2] behavioral health services, and pediatric oral and vision care, may not be routinely covered.

HHS proposes that if a state chooses a benchmark plan that is missing one of the ten categories of services required in EHB, the state must supplement its benchmark based on benefits from the largest plan within the chosen benchmark's category. If

none of the three largest plans in a chosen benchmark category contain the missing benefits, the state must supplement the plan with benefits from the federal employees health plan with the largest enrollment.

Because so many plans do not cover habilitative services or pediatric oral and vision care, HHS has proposed alternate methods of supplementing a benchmark lacking these categories of services. For habilitative services, HHS proposes to let states either require parity with rehabilitative services (for example, if a plan covers physical, occupational, or speech therapy for rehab, it must cover those services in similar scope for habilitation), or allow insurer flexibility for habilitative services initially in 2014, with HHS further defining habilitative services in the future. For pediatric oral and vision care, HHS is considering allowing states to supplement a benchmark by either using benefits from the largest federal employee dental and vision plan or the state's CHIP program.

Coverage for mental health and substance abuse services is often limited and sometimes completely absent from coverage in the individual and small employer markets today. The Mental Health Parity and Addiction Equity Act did not extend mental health parity to the individual and small employer markets, but the ACA does. All plans subject to EHB must cover mental health, substance abuse, and behavioral health care, and that coverage must be at parity with physical health services (cost sharing and treatment limits for mental health benefits cannot be more restrictive than those for physical health benefits).

Treatment of State Mandated Benefits

HHS' benchmark approach allows states to select a plan that is subject to state mandates—the small employer plan or the HMO—and thereby include applicable state mandated benefits in the EHB. States that choose a benchmark subject to state mandates will not have to defray the additional cost of those mandates, at least in 2014 and 2015. HHS' bulletin warns that it may modify its EHB approach in 2016 and beyond to exclude some state mandates from the state EHB.

Texas does not have one set of mandated benefits; rather mandates vary based on whether the underlying coverage is a "consumer choice plan" (a plan with fewer state mandated benefits) or a traditional health insurance plan; an individual, small employer, or large group market plan; and an HMO or fee-for-service plan. The attached table lists Texas' benefit mandates that apply to the small employer market, including both HMO and fee-for-service plans, and consumer choice and traditional plans.

Rider 19 in TDI's budget instructs the agency to do a study to determine which state benefit mandates exceed the essential health benefits and the cost of maintaining those mandates by December 31, 2012 or 90 days after the federal EHB rules are finalized, whichever is earlier.

Insurers Given Flexibility to Adjust Benefits

One of the most troubling parts of HHS' bulletin is the proposal to allow insurers some flexibility to adjust their benefits so long as they are "substantially equal" to the EHB.[3] This flexibility extends to both the services covered and the quantitative limits on benefits. Flexibility would be "subject to a baseline set of relevant benefits, reflected in the benchmark plan," and plans would be required to continue to offer coverage in all ten benefit categories named in the ACA. The bulletin does not say how the baseline set of benefit would be set.

HHS is considering whether to allow actuarially equivalent benefit substitutions only within each EHB category (for example, decreasing substance abuse benefits and increasing mental health benefits while maintaining the overall share of medical spending covered by the plan on average) or also across categories (for example, decreasing hospitalization benefits and increasing preventive care benefits).

HHS also intends to allow flexibility within pharmacy benefits modeled somewhat on the flexibility permitted in Medicare Part D. Insurers will have to cover at least one drug within each class of drug covered in the benchmark plan, but will have flexibility in choosing which specific drug or drugs within the class to cover.

Potential Issues with HHS' Approach

Small Employer Coverage is Generally Less Comprehensive

States have a financial incentive to select the small employer benchmark, since it is subject to state mandates and thus will keep the state from having to either eliminate state mandates or pay for the cost of the benefits that exceed the EHB benchmark. Small employer coverage, however, is likely to be the least comprehensive and have the most benefit limits of the available benchmark options. When consumers hit a benefit limit (for example, a person who needs weekly chemotherapy, but is limited to 25 doctor's office visits per year), they will have to shoulder the full cost of the service beyond the limit. This could create financial access issues, especially for people who need ongoing care for chronic or serious conditions.

Flexibility in Benefit Design May Not Benefit Consumers

HHS' benchmark approach mean there will be no national, comprehensive, uniform floor for benefits like there is in Medicare. And the additional flexibility that HHS proposes to grant insurers could also mean that consumers cannot make apples-to-apples plan comparisons among plans subject to EHB within a state. Benefit design flexibility of the kind proposed means consumers will have a more difficult time making informed choices and cannot focus just on premiums, cost sharing features, and provider networks when shopping.

On top of that, insurers could use this flexibility to design their benefits in a way that makes their plans more attractive to healthier individuals and less attractive to individuals in poor health. Benefit flexibility allows a back door way for insurers to "cherry pick" healthier enrollees, even though they will not be able to deny coverage based on a person's health statue. For example, imagine that a plan could decrease some benefits related to organ transplants (say by setting a limit on the number of hospital days covered following a transplant or by not covering the most effective therapies for keeping a body from rejecting a transplanted organ) and offset that reduction by increasing preventive care benefits. In theory, an insurer could make similar types of substitutions to discourage enrollment by people who need cancer treatment, chronic disease management, or expensive prescription drugs.

The ACA prohibits benefit design of the EHB from discriminating against individuals because of their age, disability, or expected length of life. It will be challenging to ensure that flexibility in benefit design granted to insurers does not result in discrimination, and HHS' bulletin does not lay out how federal or state governments would monitor benefit adjustments to prevent discrimination.

Prescription Benefit May be Too Limited

HHS proposes to only require coverage for one prescription drug within each class of drugs covered by the states benchmark, as opposed to covering all of the drugs within the state's chosen benchmark. If an insurer chooses to cover only one drug per class, enrollees will not have coverage that allows them to try different drugs to determine the one that is most effective.

Scope of Services within Ten Categories is not Defined

HHS' bulletin does not lay out how a state's benchmark will be determined to satisfy the criteria for including each of the ten benefit categories. For example, if a plan covers physical therapy but not speech therapy, does it satisfy the requirement to cover "rehabilitative and habilitative services and devices?" What if it has a 25 visit limit for physical therapy and does not

cover prosthetics or other rehabilitation-related devices? At what point are a plan's benefits robust enough to satisfy the statutory requirements, or alternately, at what point are the benefits so limited that they fail to offer the comprehensive set of services envisioned by the ACA? HHS should define the scope of services within each of the ten benefit categories necessary for a benchmark to satisfy the statutory EHB criteria.

State's Process to Select Its EHB Benchmark is Still Unknown

HHS' bulletin does not propose how a state will select an EHB benchmark. Nor does it set standards for robust public participation in that decision-making process.

Questions Yet to be Answered

HHS' EHB bulletin raises almost as many questions as it answers. These questions and others need to be answered when HHS puts out formal rules on EHB and related issues:

- What are the specific plans that comprise the ten benchmark options available to Texas? How do their covered benefits and limitations compare?
- What body within the state will select the EHB benchmark: the governor, the legislature, an agency, or some other entity?
- What process can states use to select an EHB benchmark? Will the process be open to the public? How will consumers and patients be allowed to participate?
- How will the EHB interact with cost-sharing features of a plan? Together will they ensure that policies cover needed benefits at a price that is affordable for insureds?
- How will the EHB be implemented in Medicaid benchmark plans?
- How will HHS evaluate the benchmark process to determine whether it should be used in 2016 and beyond?
- If the approach used in 2016 excludes some state mandated benefit from a state EHB package, how will HHS determine which mandated benefits should and should not remain covered?
- How can HHS allow insurers flexibility to adjust benefits and at the same time ensure that insurers are not using changes in benefit design to try to discourage less healthy enrollees?
- How can insurers be allowed flexibility to adjust benefits while still ensuring that consumers have access to comprehensive plans and can make effective and informed plan comparisons when shopping for coverage?

Process and Comment Period

HHS' bulletin on EHB presents the agency's intended direction on EHB implementation and serves as guidance to states in advance of releasing a formal rule. HHS is accepting public comment on its intended EHB approach as outlined in the bulletin through January 31, 2012. Comments can be emailed to EssentialHealthBenefits@cms.hhs.gov.

The public will also have a chance to comment on the formal rule, once published. We may not know the benefits and limits in the specific plans that comprise the ten benchmark options in Texas prior the comment deadline on the bulletin, but hopefully that information will be publicly available before comments are due on the EHB rule.

We do not know yet what process Texas will use to select its EHB benchmark, but it appears as if that determination must be made in the third quarter of 2012. Advocates need to be prepared not only to shape the federal rules, which will provide a framework to the states, but also to demand an open and inclusive decision-making process in Texas.

State Benefit Mandates in Texas Small Employer Plans

Small employer plans cover businesses with 2-50 eligible employees

	Traditional Plans		"Consumer Choice Plans"	
Mandates	Fee-for-service (includes PPOs)	HMO	Fee-for-service (includes PPOs)	HMO
Autism Spectrum Disorder	Yes	Yes	No	No
Brain Injury- Acquired Brain Injury	Yes	Yes	No	No
Cardiovascular Disease- Screening Tests	Yes	Yes	No	No
Chemical Dependency- Benefits	Yes	Yes	No	No
Chemical Dependency- Treatment Facility	Yes	Yes	No	No
Emergency Care	Yes	Yes	Yes	Yes
HIV, AIDS or HIV-Related Illness	Yes	Yes	No	No
Mandatory Benefit Standards – Basic Inpatient and Outpatient Health Care Services	No	Yes	No	Yes
Mental Illness-Crisis Stabilization & Residential Treatment for Children and Adolescents	Yes	Yes	No	No
Osteoporosis, Detection and Prevention	Yes	Yes	No	No
Prescription Drugs Amino Acid-based Formulas	Yes	Yes	No	No
Prescription Drugs Contraceptive Drugs And Devices And Related Services	Yes	Yes	No	No
Prescriptions Drugs- Formulary	Yes	Yes	No	No
Prescription Drugs- Oral Anticancer Medications	Yes	Yes	No	No
Prescription Drugs- Phenylketonuria (PKU)	Yes	Yes	Yes	Yes
Prosthetic/Orthotic Devices	Yes	Yes	No	No
Rehabilitation Therapies- Coverage	No	Yes	No	No
Women's Health- HPV and Cervical Cancer Testing	Yes	Yes	Yes	Yes
Women's Health- Mammography	Yes	Yes	Yes	Yes
Women's Health- Mastectomy, Reconstructive Surgery	Yes	Yes	Yes	Yes
Women's Health- Pregnancy, Complications	Yes	Yes	Yes	Yes
Women's Health-Pregnancy, Maternity Minimum Stay (If Maternity Covered)	Yes	Yes	Yes	Yes

Traditional plans must cover all state benefit mandates. Consumer choice plans must cover some, but not all state benefit mandates.

Texas has several additional state mandated benefits that apply to individual or larger employer plans, but not to small employer plans, including: hearing screening for children, children's immunizations, reconstructive surgery for craniofacial abnormalities in a child, colorectal cancer testing, diabetes, mental health parity, mental/nervous disorders with demonstrable organic disease, off-label use of prescription drugs, prostate testing, telemedicine/telehealth, temporomandibular joint (TMJ), transplant donor, and minimum stay with mastectomy or lymph node dissection.

Texas Department of Insurance, *Texas Mandated Benefits, Offers, and Coverages: Minimum Required Benefits*, Updated December 2011, www.tdi.texas.gov/hmo/hmmanben.html

[1] Health insurance exchanges are state or federally operated insurance marketplaces that will open in 2014.

[2] The HHS bulletin notes that there is no generally accepted definition of habilitative services among health plans. Habilitative services are treatments that help a person develop a new skill or function (for example, speech therapy to help a child who is not talking at the expected age), as opposed to rehabilitation, which can cover similar therapies (including physical therapy, occupational therapy, and speech therapy), but with an aim to restore function.

[3] HHS notes that CHIP plan are subject to the same equivalency standard, thus must offer benefits "substantially equal" to the CHIP benchmark chosen by the state.

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