



REALIZING HEALTH REFORM'S POTENTIAL

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Implementing the Affordable Care Act: Revisiting the ACA's Essential Health Benefits Requirements

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Abstract The Affordable Care Act broadens and strengthens the health insurance benefits available to consumers by requiring insurers to provide coverage of a minimum set of medical services known as “essential health benefits.” Federal officials implemented this reform using transitional policies that left many important decisions to the states, while pledging to reassess that approach in time for the 2016 coverage year. This issue brief examines how states have exercised their options under the initial federal essential health benefits framework. We find significant variation in how states have developed their essential health benefits packages, including their approaches to benefit substitution and coverage of habilitative services. Federal regulators should use insurance company data describing enrollees’ experiences with their coverage—information called for under the law’s delayed transparency requirements—to determine whether states’ differing strategies are producing the coverage improvements promised by reform.

OVERVIEW

The Affordable Care Act’s “essential health benefits” rule obligates insurers in the individual and small-group markets to cover 10 categories of “essential” medical services, including hospitalization, prescription drugs, and maternity and newborn care (Exhibit 1).¹ This requirement was a signature component of reform, designed to ensure that Americans across the country would be protected by a common set of robust insurance benefits comparable to those provided by employer-based coverage.

When federal officials implemented these requirements, they adopted a regulatory framework that left many important decisions to the states.² This approach came as a surprise to many, including the Institute of Medicine and some of the law’s drafters, who had anticipated a more uniform standard.³ Officials pledged to reexamine their policy, which they described as “transitional,” in time for the 2016 coverage year.⁴ To date, they

Exhibit 1. The Affordable Care Act's 10 Essential Health Benefits Categories

1. Ambulatory patient services
 2. Emergency services
 3. Hospitalization
 4. Maternity and newborn care
 5. Mental health and substance use disorder services, including behavioral health treatment
 6. Prescription drugs
 7. Rehabilitative and habilitative services and devices
 8. Laboratory services
 9. Preventive and wellness services and chronic disease management
 10. Pediatric services, including oral and vision care
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Source: The Affordable Care Act, Section 1302(b)(1).

have not published new regulations or guidance, leaving only a few months to assess how the current rules are working for consumers and whether they should be modified.

As it stands, federal regulations for 2014 and 2015 do not establish a single, nationally uniform package of health services. Instead, the U.S. Department of Health and Human Services (HHS) gave states discretion to determine the specific benefits they deem essential.⁵ This approach was well-received by many state officials, who valued the opportunity to tailor benefit standards to reflect state priorities, and by insurers, who retained more control over benefit design.⁶ Groups representing consumers and providers were less supportive, however, expressing concern that the degree of flexibility found in the rules undermines the law's promise of consistent, meaningful coverage.⁷

FINDINGS

States Set the Benchmark

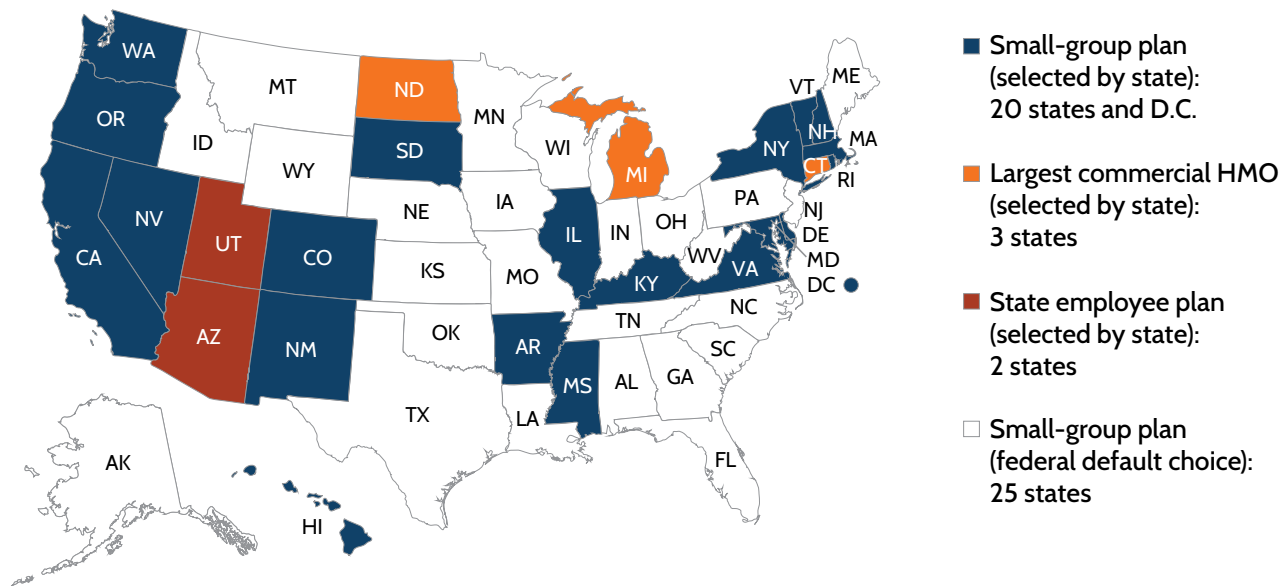
To flesh out the essential health benefits package, HHS asked each state to select an existing health plan to serve as a benefit benchmark.⁸ States could choose among 10 federally prescribed options, including one of the largest three small-group plans available in the state, any of the largest three state employee health plans, any of the largest three national Federal Employees Health Benefits Program plan options open to federal employees, or the state's largest commercial HMO.⁹ In general, the specific items and services provided in the categories of essential benefits by the benchmark plan would constitute the essential health benefits package in the state.¹⁰

About half of states picked a benchmark; the others did not and were assigned a default option—the largest health plan offered in the largest small-group product in the state.¹¹ For 2014 and 2015, most states' essential health benefits packages are pegged to the benefits offered by a small-group plan (Exhibit 2).

Different States, Different Standards

Selection of a benchmark plan is only the first of many ways in which states shape the essential health benefits package. State policymakers also have authority over other critical implementation issues, four of which are addressed here. In these areas, among others, state choices have a direct impact on the benefits that consumers receive. This is true in instances in which choices result in affirmative

Exhibit 2. State Approaches to Selection of an Essential Health Benefits Benchmark Plan (2014–2015)



Notes: Nebraska selected a benchmark plan that was not among the 10 options identified in federal guidance and was instead assigned the default choice. Maryland initially selected a state employee plan but switched to a small-group plan during the federal rulemaking process. Source: Authors' analysis.

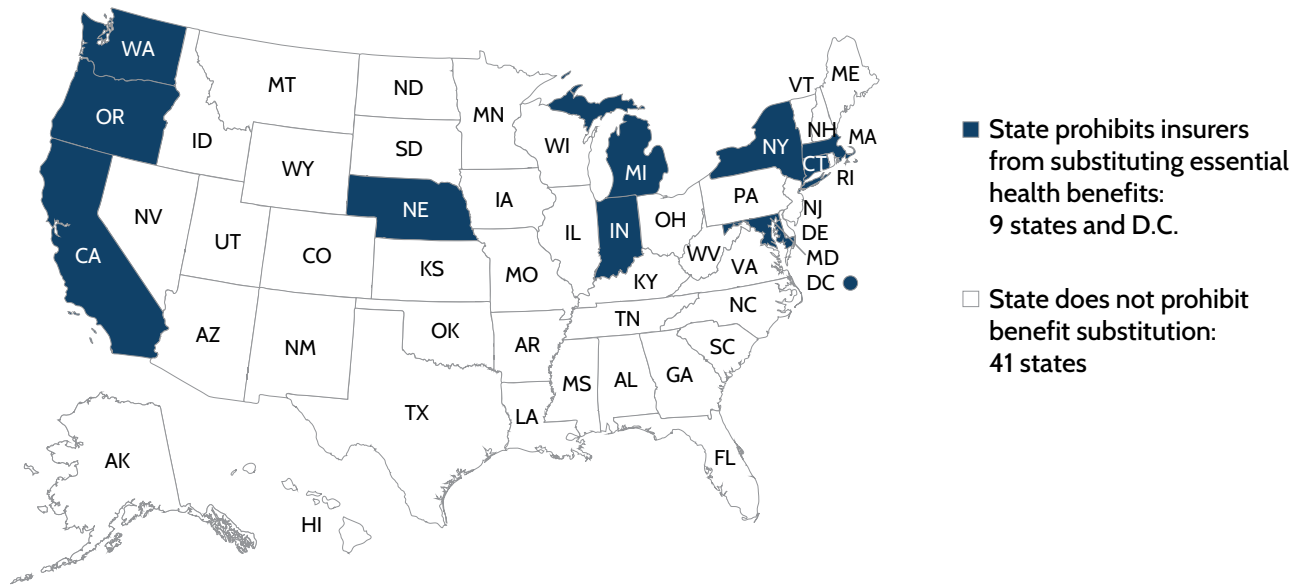
guidance on an issue, but also in cases where they do not. A hands-off approach often has the effect of giving a state's insurers greater discretion over the design of essential benefits.

Benefit substitution. Federal rules allow insurers to offer coverage that differs from the state's benchmark plan by replacing one benefit in an essential health benefits category with a different one from within the same category.¹² For example, in a state where the benchmark plan covers blood screens for ovarian cancer, an insurer could decline to cover that benefit and instead provide coverage of a different laboratory service. Substitution must involve "actuarially equivalent" benefits, may not occur across benefit categories—insurers cannot exchange a maternity benefit for unrelated ambulatory services, for example—and is not permitted for prescription drugs.¹³

Some policymakers see value in substitution because it gives insurers greater power to differentiate their coverage offerings and provide consumers more choices. Others prefer to limit benefit variation, to make it easier for consumers to make apples-to-apples comparisons among plans and to reduce opportunities for insurers to use benefit design to cherry-pick healthier enrollees.¹⁴ Nine states and the District of Columbia prohibited benefit substitution in 2014, while the rest allowed insurers to retain this flexibility (Exhibit 3).

Habilitative services. Prior to health reform, coverage for habilitative services (i.e., treatments that help people gain or maintain functional skills like walking or speaking) varied widely.¹⁵ Because these benefits were not well defined by the private market and were often absent from state benchmark plan options, federal regulators gave states additional power to create their own coverage standard. States could select a benchmark plan that did cover habilitative services, in which case those benefits would define the category; or, they could provide official guidance describing which services must be included.¹⁶ In states that declined these options, responsibility for defining habilitative services shifted to individual insurers. Carriers in these states may offer coverage at parity with rehabilitative services or determine for themselves an appropriate level of benefits and report that decision to HHS.¹⁷

Exhibit 3. State Approaches to Regulation of Essential Health Benefit Substitution (2014)

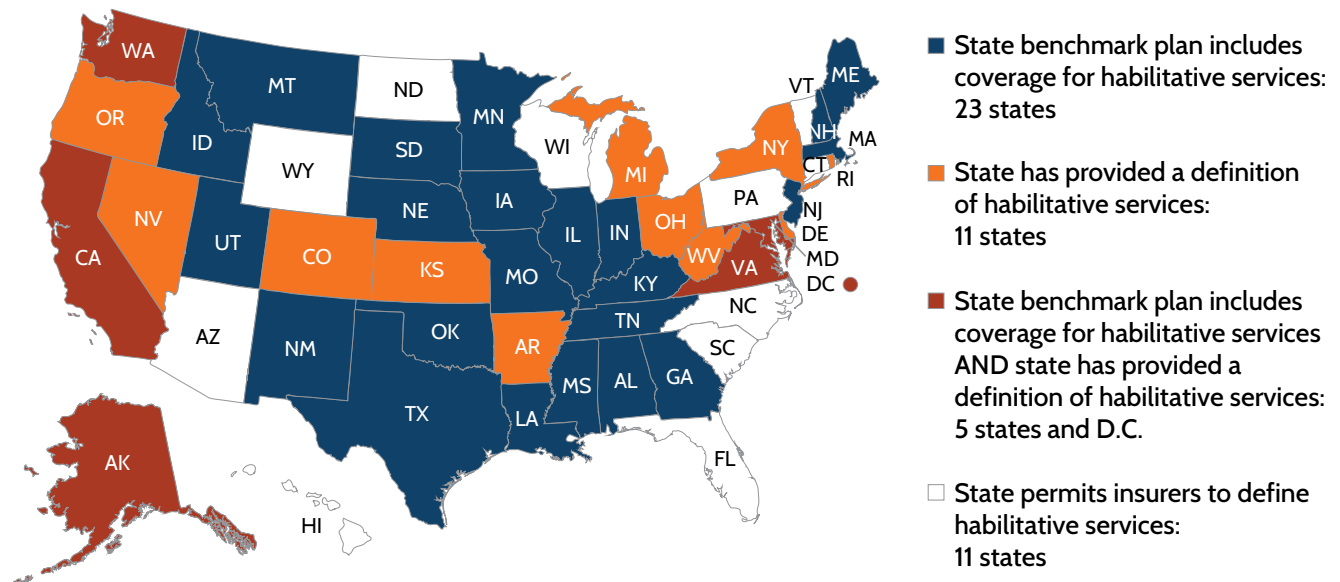


Notes: New York and Oregon prohibit substitution for standardized plans but permit at least limited substitution in nonstandardized plans. Washington bars substitution for plans issued or renewed through the end of 2016, but will allow the practice in years thereafter. Source: Authors' analysis.

In 2014, 29 states' benchmark plans provided some level of coverage for habilitative services; 16 states and the District of Columbia provided a state-specific definition for the coverage category; and 11 allowed insurers to designate essential habilitative services (Exhibit 4).

State-mandated benefits. All states have laws that require health insurers to provide coverage for certain treatments or services.¹⁸ Under federal regulations, benefit mandates enacted by

Exhibit 4. State Approaches to Defining Coverage for Habilitative Services (2014)



Source: Authors' analysis.

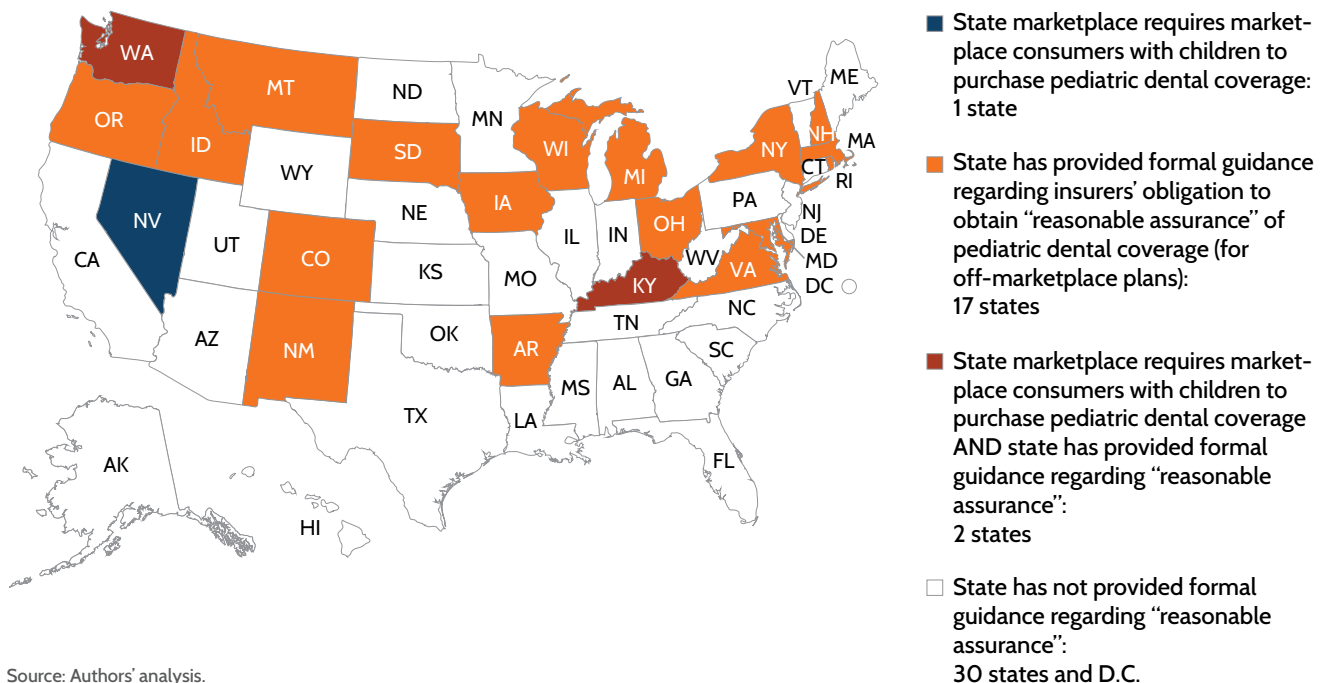
a state before 2012 are incorporated into the state's essential health benefits package.¹⁹ States may create mandates after that date, but must pay the additional premium costs associated with the new benefits.²⁰

Although many assumed this funding requirement would deter states from adopting new mandates, the practice has continued in diverse ways.²¹ Some states have required new benefits only in plans not subject to the essential health benefits rules. Nebraska, for example, enacted a law mandating coverage for treatments of autism in the individual and group markets but exempted plans that are required to provide essential health benefits.²² Thus, in practice, the state's requirement applies to large-group coverage and to plans in the individual and small-group markets that have grandfathered status. Other states, meanwhile, have imposed broadly applicable requirements without exceptions, as Arkansas has done for coverage of craniofacial surgery.²³

Pediatric dental services. The health law identifies pediatric dental services as an essential benefit, but federal regulations treat its purchase and sale somewhat differently than the other essential health benefits categories. While shoppers on the marketplace must have the option to buy pediatric dental coverage, federal default rules allow consumers to purchase a policy without these benefits included.²⁴ (Pediatric dental coverage is sometimes sold in conjunction with a policy offering the other essential benefits, but is more frequently available as a standalone product.²⁵) In contrast, plans offered outside the marketplace must include pediatric dental benefits unless an insurer is "reasonably assured" that the consumer has obtained such coverage elsewhere, through a marketplace-certified standalone dental policy.²⁶

Three state-based marketplaces have expanded on this federal framework by requiring marketplace consumers who have children to purchase pediatric dental coverage. Outside the marketplaces, 19 states have provided formal guidance regarding what insurers must do to be reasonably assured of a consumer's coverage status (Exhibit 5).

Exhibit 5. State Approaches to Coverage for Pediatric Dental Services (2014)



Source: Authors' analysis.

CONCLUSION

The Affordable Care Act entrusts federal regulators with responsibility for monitoring how consumers are faring under the essential health benefits framework.²⁷ Officials must assess whether enrollees are having a difficult time obtaining needed services because of gaps in coverage or the cost of care, and modify the package accordingly.²⁸ In addition to this statutory obligation, regulators have promised to revisit the state benchmark plan approach for 2016 and beyond.²⁹

These are not easy tasks. To perform them, regulators will need to understand both the substantial variation in state policy decisions—and the real-world effect of those choices on a diverse group of consumers.

It is thus critical that federal officials have access to concrete information that shows how enrollees are experiencing coverage. Data on consumer complaints, use of out-of-network and non-covered services, and claims appeals will be vital in evaluating the adequacy of states' essential health benefits packages. Insurers must report this information, thanks to transparency requirements contained in the health law.³⁰ However, implementation of these transparency rules has been delayed, and the window for regulators to act on essential health benefits in time for the 2016 plan year is closing rapidly.³¹ If officials are to be prepared for the tasks ahead, these disclosure tools should be implemented as soon as possible.

NOTES

- ¹ Pub. L. 111-148, 124 Stat. 782 (2010) § 1302(b)(1) (codified at 42 U.S.C. § 18022(b)(1)). The essential health benefits requirement applies to health coverage sold in the individual and small-group markets, both inside and outside of the Affordable Care Act's new insurance marketplaces (also known as exchanges). Public Health Service Act § 2707(a) (codified at 42 U.S.C. § 300gg-6(a)); 45 C.F.R. §147.150. It does not apply to the large-group market, to self-insured health plans, to grandfathered plans (those plans in existence before the Affordable Care Act that have not made significant changes since its enactment in March, 2010), or to policies renewed pursuant to the Obama Administration's transitional policy for expiring coverage. U.S. Department of Health and Human Services, "Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016," March 5, 2014, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>; see also K. Lucia, S. Corlette, and A. Williams, "The Extended 'Fix' for Canceled Health Insurance Policies: Latest State Action," *The Commonwealth Fund Blog*, June 10, 2014.
- ² Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834 (Feb. 27, 2013) (the "ACA Essential Health Benefits Final Rule").
- ³ Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost* (Washington, D.C.: The National Press, Oct. 2011); H. Waxman, S. Levin, G. Miller et al., "Letter to the Honorable Kathleen Sebelius," Feb. 6, 2012, <http://democrats.energycommerce.house.gov/sites/default/files/documents/Sebelius-PPACA-Essential-Health-Benefits-2012-2-6.pdf>.
- ⁴ For example, see ACA Essential Health Benefits Final Rule, 78 Fed. Reg. 12834, 12838, 41, 43-44 (Feb. 27, 2013); U.S. Department of Health and Human Services, "Frequently Asked Questions on Essential Benefits Bulletin," Feb. 17, 2012, <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.
- ⁵ 45 C.F.R. § 156.100.
- ⁶ National Association of Insurance Commissioners, "NAIC Comments on Proposed EHB/AV/Accreditation Rule," Dec. 19, 2012, http://www.naic.org/documents/index_health_reform_comments_121219_ehb.pdf; America's Health Insurance Plans, "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (CMS-9980-P)—AHIP Comments," Dec. 21, 2012, <http://www.ahip.org/CommEHBVAccPropReg12212012/>.
- ⁷ American Cancer Society Cancer Action Network, "Essential Health Benefits Comment Letter," Dec. 20, 2012, <http://www.acscan.org/content/wp-content/uploads/2012/12/EHB-comment-ltr-FINAL-Dec-20-2012.pdf>; American Hospital Association, "CMS-9980-P Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule" (Vol. 77, No. 227, Nov. 26, 2012)," Dec. 20, 2012, <http://www.aha.org/advocacy-issues/letter/2012/122012-cl-cms9980p.pdf>.
- ⁸ 45 C.F.R. §§ 156.100, 156.110.
- ⁹ 45 C.F.R. § 156.100.
- ¹⁰ 45 C.F.R. § 156.115.
- ¹¹ S. Corlette, K. Lucia, and M. Levin, *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan* (New York: The Commonwealth Fund, March 2013).
- ¹² 45 C.F.R. § 156.115.

- ¹³ Ibid.
- ¹⁴ C. Monahan, S. Dash, K. Lucia et al., *Realizing Health Reform's Potential: What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces* (New York: The Commonwealth Fund, Dec. 2013); and S. Rosenbaum, N. Lopez, D. Mehta et al., *Realizing Health Reform's Potential: How Are State Insurance Marketplaces Shaping Health Plan Design?* (New York: The Commonwealth Fund, Dec. 2013).
- ¹⁵ S. Rosenbaum, *Habilitative Services Coverage for Children Under the Essential Health Benefit Provisions of the Affordable Care Act* (Palo Alto, Calif.: Lucile Packard Foundation for Children's Health, May 2013).
- ¹⁶ 45 C.F.R. § 156.110.
- ¹⁷ 45 C.F.R. § 156.115.
- ¹⁸ V. C. Bunce and J. P. Wieske, *Health Insurance Mandates in the States 2010* (Alexandria, Va.: Council for Affordable Health Insurance, Oct. 2010).
- ¹⁹ 45 C.F.R. § 155.170. A consequence of this policy is to entrench some of the variation that marked state benefit standards, prior to the Affordable Care Act, in the benefit packages available to consumers in the reformed market.
- ²⁰ 45 C.F.R. § 155.170. Cost defrayment is required only in the case of a state rule that mandates coverage for care, treatment, or services. State requirements that relate to provider types, cost-sharing, reimbursement methods, or benefit delivery methods—for example, telemedicine—are not benefit mandates within the meaning of the federal framework. ACA Essential Health Benefits Final Rule, 78 Fed. Reg. 12834, 12838 (Feb. 27, 2013).
- ²¹ M. Andrews, "Health Law Tempers New State Coverage Mandates," *Kaiser Health News*, Sept. 16, 2014, <http://kaiserhealthnews.org/news/health-law-tempers-new-state-coverage-mandates/>.
- ²² Neb. Rev. Stat. § 44-7,104.
- ²³ Ark. Code § 23-79-1502; Arkansas Insurance Department, "Bulletin No. 9-2014: 2015 Plan Year Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Marketplace," April 11, 2014, <http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf>.
- ²⁴ ACA Essential Health Benefits Final Rule, 78 Fed. Reg. 12834, 12853 (Feb. 27, 2013).
- ²⁵ A. Snyder, K. Kanchinadam, C. Hess et al., *Improving Integration of Dental Health Benefits in Health Insurance Marketplaces* (Washington, D.C.: National Academy for State Health Policy, April 2014).
- ²⁶ ACA Essential Health Benefits Final Rule, 78 Fed. Reg. 12834, 12853 (Feb. 27, 2013).
- ²⁷ Pub. L. 111-148, 124 Stat. 782 (2010) § 1302(b)(4)(G) (codified at 42 U.S.C. § 18022(b)(4)(G)).
- ²⁸ Pub. L. 111-148, 124 Stat. 782 (2010) § 1302(b)(4)(G) & (H) (codified at 42 U.S.C. § 18022(b)(4)(G) & (H)).
- ²⁹ U.S. Department of Health and Human Services, "Frequently Asked Questions on Essential Benefits Bulletin," Feb. 17, 2012, <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

- ³⁰ J. Giovannelli, K. Lucia, and S. Dash, “The Affordable Care Act’s Disclosure Rules: Can They Improve Coverage, Raise Care Quality, and Cut Costs?” *The Commonwealth Fund Blog*, Jan. 15, 2014.
- ³¹ U.S. Departments of Labor, Health and Human Services, and the Treasury, “FAQs About the Affordable Care Act Implementation Part XV,” April 29, 2013, <http://www.dol.gov/ebsa/faqs/faq-aca15.html>. Officials reiterated the delay in guidance issued in October 2014. U.S. Department of Health and Human Services, REGTAP Frequently Asked Questions ID No. 5850, Oct. 20, 2014, https://www.regtap.info/faq_view.php?i=5850.

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