What Is So Essential About Health Benefits?

The Federal Government Recently Released the Final Rule Giving States Flexibility to Set Standards for the ACA's Essential Health Benefits

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As time moves forward, lawmakers are working hard to implement the Patient Protection and Affordable Care Act ("ACA"). Every year since 2010, new pieces of the ACA have come into effect. This pattern is scheduled to continue through 2015. Along this timeline, and in about a half a year, lies the implementation of the essential health benefit ("EHB") requirement. A regulatory structure provides guidance for the EHB requirement, including for the EHB for mental health and substance use disorder. Only time will tell how the implementation of the EHB requirement will play out.

I. What are Essential Health Benefits?

Under the ACA, beginning in 2014 all non-grandfathered[1] individual and small group health plans must provide EHBs.[2] The ACA outlines ten categories of EHBs:

1. Ambulatory patient services,
2. Emergency services,
3. Hospitalization,
4. Maternity and newborn care,
5. Mental health and substance use disorder services, including behavior health treatment,
6. Prescription drugs,
7. Rehabilitative and habilitative services and devices,
8. Laboratory services,
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care.[3]

States may add more categories of EHBs.[4]

The ACA directs the Secretary of the Department of Health and Human Services (the "Secretary" and "HHS") to define the scope of the EHBs.[5] At minimum, the ACA requires that EHBs be equal in scope to benefits offered by a "typical employer plan."[6]

II. The Secretary Has Issued the Final Rule defining the Scope of EHBs.

On February 20, 2013, HHS issued its final rule implementing the ACA's EHB requirement. HHS has given states the opportunity to define the scope of EHBs – that way states may take into account the needs of their respective residents. For

2014 and 2015,[7] a state may select a base-benchmark plan as the reference for defining EHB in the state. States may choose (1) the largest plan by enrollment in any of the three largest small group insurance products in the state, (2) any of the three largest state employee health benefit plans, (3) any of the three largest Federal Employees Health Benefits Program plans, or (4) the largest insured non-Medicaid HMO in the state. A little over half of the states have selected a benchmark plan for their state. The other states will use as a benchmark the largest small business plan in the state. Further, if a benchmark plan is missing any of the ten categories of EHBs, the final rule provides direction on how a state or HHS, depending on what benchmark plan applies, will supplement the plan to address the missing category. Base-benchmark plans will likely need to be supplemented in the areas of pediatric oral and vision and habilitation services, which are often not covered by employer sponsored plans. Benchmark plans will not have to cover abortion services, routine non-pediatric dental services or eye exams, non-medically necessary orthodontia, or long-term/custodial nursing home benefits.

As a means to define the scope of EHBs, New Jersey has chosen to set as an EHB benchmark a plan from the largest small group product (type (1) above), and that is: Horizon HMO, Access HAS Compatible. Because this plan does not provide for pediatric oral and vision care, those services will be supplemented by the Children's Health Insurance Program (oral) and the Federal Employee Dental and Vision Insurance Program (vision).

III. Will the EHB requirement improve mental health coverage?

One area in particular that many are watching closely to see if the EHBs improve care is the field of mental health. Many have argued that the mental health and substance use disorder system in this country has been insufficient for too many years. Experts have pointed out that the lack of access to mental health may have played a significant role in some of our country's most tragic violent shootings, including the recent shootings in Arizona, Colorado, Connecticut, Wisconsin, and Virginia. It has been well documented that the perpetrators of these horrific shootings exhibited signs of serious mental illness prior to carrying out their murderous plots. Much time and effort is being spent trying to determine how a better system of mental health care could be devised to more effectively identify and address the need for mental health in the hope that tragedies like these can be avoided in the future. On a smaller, more personal scale, many of us may know someone who has suffered from a mental illness or a substance use disorder but could not afford to pay for treatment, or whose benefits were cut off prematurely. In other words, the mental health/substance use disorder coverage was available but not adequate. Whatever one's personal experience may be, there is a growing consensus as a country that the mental health system needs to be improved to more adequately provide and pay for mental health services, and that there is no better time than the present to tackle this issue.

The ACA has endeavored, and indeed made it the law, to provide adequate mental health and substance use disorder services. The ACA sets the groundwork by making mental health and substance use disorder services an EHB. The final rule requires that each state provide a benchmark plan that will set forth what the minimum standards are for this EHB. Finally, the ACA requires group health plans to offer mental health and substance use disorder benefits that are comparable to coverage for general medical and surgical care. This requirement builds on the federal parity law – the Paul Wellstone and Pete Domenici Mental Health Parity and Additional Equity Act of 2008. While almost all large group plans, and most small group plans, provide coverage for some mental health and substance use disorder services, there are gaps in coverage. The parity rule should fill these gaps.

According to a research brief released by HHS with the final rule,[8] the ACA gives access to mental health and substance use disorder services to 32.1 million Americans and greater access to services, as a result of the parity law, to 30.4 million Americans who currently have some but inadequate benefits.

While the services may now be more accessible, it still remains to be seen whether troubled individuals will effectively take advantage of them.

IV. What's Next?

While the EHBs will help to ensure more uniform minimum coverage for individuals, the implementation of the comprehensive set of EHBs is predicted to make plans more expensive than they are today. The explanation for this is simple: insurers and businesses must now pay for more services. The additional cost may consequently cause increased premiums. However, the EHB requirement is intended not only to ensure that consumers in the individual and small group markets have adequate coverage, but also to improve competition among health plans by standardizing coverage choices. Thus, competition may slow the rise of premium rates. Regardless, the goal is better health care, and with the EHBs in place, it appears to be reachable.

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Footnotes

[1]Grandfathered plans are plans that were in place when the ACA was enacted and that have not been changed in certain, specified ways.

[2]A small group health plan is sponsored by a small employer, which, under the ACA, employed an average of at least one but not more than 100 employees on a business day during the preceding calendar year and who employed at least one employee on the first day of the plan year.

[3]Section 1302(b)(1)(A)-(J).

[4]See § 1301(b)(5); see also U.S. Dept. of Health & Human Servs., ESSENTIAL HEALTH BENEFITS AND ACCESS TO PROVIDERS, http://www.healthcare.gov/prevention/nphpphc/advisorygrp/essential-health-benefits-10032011.pdf (last visited July 12, 2012).

[5]Section 1302(b).

[6]The ACA required the Department of Labor to take a survey of the benefits provided by employer plans and submit a report to HHS to assist in defining the essential health benefits. See § 1302(b)(2)(A).

[7]HHS plans to revisit this process for 2016.

[8]http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf.