



Child Health Advocates' Guide to Essential Health Benefits

by Joe Tuschner

One of the Affordable Care Act's important features for health insurance consumers is the establishment of a package of essential health benefits that will help assure that certain plans—including all exchange plans—provide adequate benefits to their enrollees. The essential health benefits package will define the minimum set of benefits that new health plans¹ must offer for private market individual and small group plans as well as for Medicaid enrollees in benchmark coverage² and those covered by state Basic Health Programs. While many expected the Department of Health and Human Services to define those services that will comprise the essential health benefits, it instead indicated that each state will select an essential health benefit package for 2014 and 2015. State advocates may wish to work for the selection of a package that best serves the needs of children and families.

This guide is intended to inform state advocates and link them to useful resources as they seek to influence their states' choice of essential health benefits. For links to even more related resources, see CCF's [Essential Health Benefits Resource List](#). Throughout this guide, look for suggested Action Steps identified with shaded text. See the Action Steps box for a summary of our recommendations.

Who will be covered by the essential health benefits?

Essential health benefits (EHBs) are the minimum benefits that the Affordable Care Act (ACA) requires to be offered by non-grandfathered health plans in the individual and small group markets both within and outside of the exchanges as well as for Medicaid enrollees in benchmark coverage and Basic Health Plan enrollees. Large group and self-insured plans are not required to offer the EHBs. See Table 1.

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Table 1			Must Provide Essential Health Benefits
Exchange Private Plans	Small Group		Yes
	Non-Group		Yes
Non-Exchange Private Plans	New Plans	Self-insured	No
		Large Group	No
		Small Group	Yes
		Non-Group	Yes
	Grandfathered Plans	Self-insured	No
		Large Group	No
		Small Group	No
		Non-Group	No
Public Plans	Medicaid	Non-benchmark coverage	No
		Benchmark or benchmark-equivalent coverage	Yes
	Basic Health		Yes



Action Steps

Given the rapid timeframe outlined in the Bulletin, some states are already moving forward to analyze choices and select their essential health benefits. Child health advocates have been and will continue to be involved as states take action. We suggest the following steps, some of which are already underway in some states, for engaging in advocacy around the EHBs:

- 1. Build or strengthen coalitions of interested organizations.** Potential candidates for coalition partners around EHBs include provider associations representing pediatricians, other physicians, nurses, clinics, and hospitals; disease groups who stand up for access to care for children and others with certain conditions like diabetes, autism, leukemia, and others; and traditional allies who support better coverage for low and moderate income families.
- 2. Push for a detailed comparison of your state's benchmark choices.** It's important to know which benefits may be at stake in the choice of a benchmark and the areas where potential benchmarks differ are often in benefits important to children. Advocates can ask state insurance departments or other officials to complete summary analyses like those done in California, Maine, Virginia, and Washington to see whether benchmark choices have major differences. However, advocates should also press stakeholders to look more closely at what the choices do and do not cover—they should understand where the plans limit services that may be important for children, rather than only the covered/uncovered distinction for an entire category of services. For instance, are there visit limits for occupational, speech, or other therapies? If pediatric vision services are covered, what are the limits to the coverage?
- 3. Pay attention to pediatric dental benefits.** Not only are dental benefits important for children, they will be a particular cause for concern with regard to the essential health benefits. They are particularly complicated due to current market practices and the provisions of the ACA that require pediatric dental benefits to be offered and allow them to be provided by separated plans. Insurers may wish to replace existing dollar limits with other coverage limits such as a maximum number of services. An important step will be to examine your state's separate CHIP dental benefit if your state has one and assess whether this is an adequate package for kids. The [Children's Dental Health Project](#) can be a good resource for information on this set of issues.
- 4. Review state mandates.** Child advocates should familiarize themselves with their states' benefit mandates that are important for children. For instance, what coverage does your state mandate for children? To which markets do these mandates apply? Many assume that a small group benchmark would automatically include all relevant mandates, however, a Center for Studying Health System Change brief shows that this may not always be the case.³ Are the mandates necessary for the relevant coverage to be provided—i.e., do plans not covered by the mandate offer similar coverage despite the lack of a requirement to do so? These questions can help inform the choice of a benchmark plan.
- 5. Look for allies in both the executive and legislative branch.** States may select their EHBs in any way that is consistent with state law. If legislators move to select a benchmark plan or set the essential health benefits, they will still likely rely on analysis or recommendations from the insurance department, particularly for how the benchmark must be supplemented to include the ten categories. On the other hand, if the EHBs will be set by executive action, the legislature may present another venue for advocates to make the case for a set of benefits that meets the needs of children and families.
- 6. Help assure that ACA requirements have force.** While the Secretary of HHS bears responsibility for enforcing the ACA's provisions, as in other areas of ACA implementation, we can expect deference to state decisions on EHBs. Advocates should remember that selecting a benchmark is only one step in setting the essential health benefits. They still must be supplemented, if necessary, to fulfill the ten categories required by the ACA. And the benefits may not lead to discrimination based on age, disability, or expected length of life. Advocates may need to make the case that adjustments are necessary to meet these provisions and provide suggestions for appropriate adjustments.



EHBs set the minimum coverage standard for:

- **Private exchange plan enrollees.** All exchanges, regardless of whether they are state, federal, or administered as a “partnership,” are required to offer only plans that include EHBs. 3.9 million children and 7.7 million parents are expected to enroll in exchange plans.⁴
- **Private non-exchange plan enrollees.** 380,000 children and 590,000 parents are expected to enroll in non-exchange individual market plans.⁵ Estimates are not available for non-exchange small group market plans, but they will enroll additional children and adults.
- **Medicaid enrollees with benchmark coverage.** Many parents and other adults with incomes under 138 percent of the federal poverty level that will be newly eligible for Medicaid in 2014 will be provided benchmark benefits including the EHBs.
- **Basic Health Plan enrollees.** States that adopt this option will cover relatively few children (only those not eligible for CHIP with incomes below 200 percent of the federal poverty level) and parents and adults between 133 and 200 percent of the federal poverty level.

The total number of children to be covered by private plans offering the EHBs remains small compared to the 32.5 million children covered by Medicaid and CHIP. Nonetheless, millions of children will rely on the benefits provided through EHB plans—the EHB protections will be especially important for children, parents, and others who purchase coverage in today’s individual market, where plans are more likely to lack key benefits. And as an officially-sanctioned definition of essential coverage, the EHBs could come to serve as a model even for those plans not required to offer them, such as in the large group employer market.

What benefits must be part of the EHBs?

[Section 1302 of the ACA](#) sets out the requirements for the essential health benefits. While not part of the ACA, an HHS [Bulletin](#) published in December 2011 advises that states will have the responsibility of selecting their own essential health benefits based on an existing employer-based health plan in the state.⁸ States are empowered to choose a “benchmark” plan from among several choices—see **Choices for States** on page 4.

Certain benefits, though, must be part of the essential health benefits whether or not they are included in the benchmark plan a state chooses. The ACA lists ten categories of benefits that must be part of the EHB package, among them “Pediatric services, including oral and vision care.”⁷ The law itself provides no further definition of what specific services the categories should include.

The law further requires that the scope of the EHBs be “equal to the scope of benefits provided under a typical employer plan.” Section 1302 also establishes some specific guidelines in defining the EHBs. Benefits may not be designed “in ways that discriminate against individuals because of their age, disability, or expected length of life” and are required to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.”

The HHS Bulletin clarifies that states’ EHB packages must include benefit protections established in other parts of the ACA, including parity for mental health services and preventive services offered at no cost to enrollees. For infants, children, and adolescents, the preventive services requirement incorporates the services recommended in the American Academy of Pediatrics’ *Bright Futures* initiative.

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Note that under the law, the EHBs will define only the minimum covered benefits of plans to which they apply—not the plans' cost sharing. Covered benefits and cost sharing together determine the value of a health plan, so an adequate set of EHBs is only one aspect of creating plans that meet the needs of children and families.⁸

What's at stake for children?

Like other health insurance consumers, children and their parents stand to gain important protections through the essential health benefits. Since EHBs apply across the individual and small group markets, millions of people will have a minimum benefit floor for their health coverage. While insurers could choose to offer coverage beyond the minimum requirements of the EHBs, in exchange plans the costs for such extra benefits will not be supported by premium tax credits and cost-sharing reductions for those who qualify. This will create a strong disincentive for insurers to offer benefits that are not defined as essential health benefits.

Children's need for adequate benefits is particularly acute due to their continuous growth and development. Children require different health services than adults, including appropriate preventive health screenings depending on their age and development stage. Children's growing bodies may also necessitate new durable medical equipment (like wheelchairs) on a more frequent schedule than adults. In its [Scope of Health Care Benefits for Children policy statement](#), the American Academy of Pediatrics (AAP) outlines the services that are essential for children.⁹ Among others, AAP includes:

- *Preventive educational and counseling services like anticipatory guidance, tobacco cessation, and services related to maintaining healthy weight;*
- *Corrective audiology and speech therapy services, delivered by those trained in the care of children;*

- *Special diets, infant formulas, nutritional supplements, and delivery (feeding) devices for nutritional support and disease-specific metabolic needs; and*
- *Physical, occupational, speech (including speech-generating devices), and respiratory therapy.*

To meet the needs of children, the EHBs should include these pediatric services. See Supplementing the Benchmark Plan on page 7 for more on ensuring an appropriate definition of pediatric services.

Choices for States

As mentioned above, HHS has indicated in a bulletin released in December 2011 that it would give states the authority to choose EHBs. The [Bulletin](#) (and a subsequent [Frequently Asked Questions document](#)¹⁰) outlines an approach in which states have the discretion to choose a benchmark set of benefits from among as many as ten existing health plans. The benefits covered by the benchmark plan would serve as the base for the state's essential health benefits. If the benchmark plan lacks coverage for one of the ten categories of services required by the ACA, the state would have to add coverage for that category from one of the remaining benchmark choices. The benchmark plan may also need to be altered to comply with the ACA's non-discrimination provisions. The ten plans available for states to choose as benchmarks are:

- The largest plan in any of the three largest small group market insurance products in the state¹¹,
- The three largest federal employee health plans,
- The three largest state employee health plans, and
- The largest non-Medicaid HMO in the state.

In order to allow time for insurers to roll out the plans for coverage beginning January 1, 2014,



the Bulletin specifies that states should select a benchmark plan by the third quarter of 2012, using enrollment data from the first quarter of 2012 to determine which plans qualify as benchmark choices. If a state does not choose a benchmark plan by this deadline, the default plan will be the largest plan in the largest product in the small group market.¹² Once chosen in 2012, the benchmark would be effective in a state for 2014 and 2015. HHS intends to reassess the benchmark approach for 2016. See Figure 1.

Who Decides for a State?

The HHS Bulletin and FAQ provide little direction on how states should choose a benchmark plan and set the EHBs. They indicate that state law should determine who has the authority to make the selection—the legislature or the executive branch through the governor or chief insurance regulator. If state law allows the insurance regulator broad authority to set market rules, he or she may be able to make the choice. Alternatively, if state statutes control health insurance practices in the individual and small group markets, legislation may be necessary. **An important initial task in EHB advocacy, then, is to assess how the EHB determination will be made in your state.**¹³

What Decisions Must Be Made?

Whoever makes the final decision, policymakers, advocates, and other stakeholders will want to analyze the state’s options before the EHBs are set. The process can be thought of as having three steps:

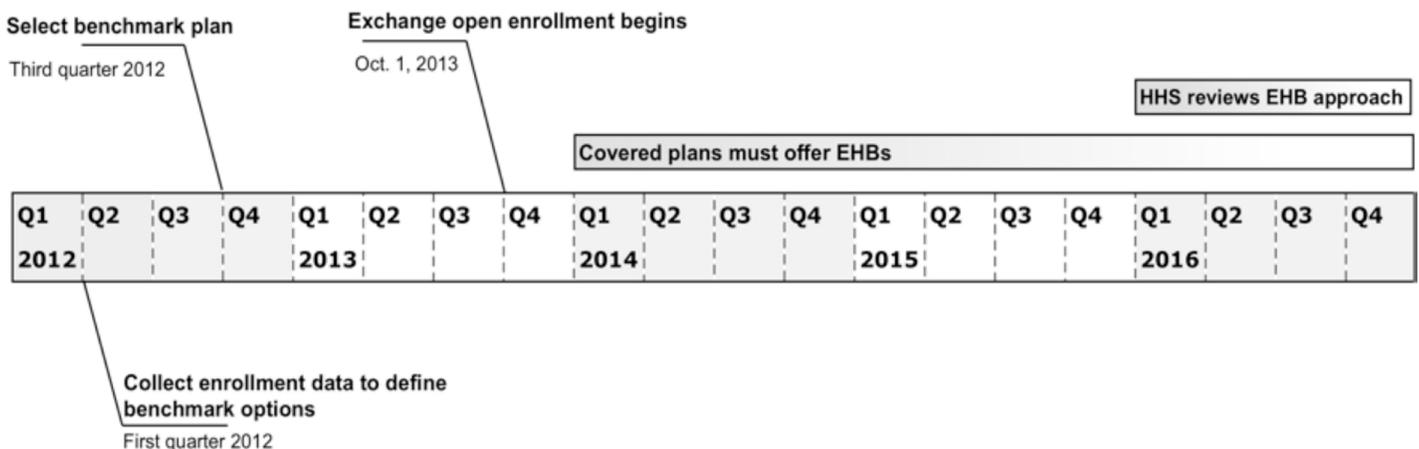
1. Identifying benchmark choices,
2. Comparing and choosing a benchmark, and
3. Supplementing the benchmark as necessary to meet the requirements of the ACA.

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Identifying Benchmark Choices

Before a benchmark is chosen, stakeholders need to know which plans are among the allowable benchmark choices and what they cover. HHS has released an [illustrative list of the three largest small group products in each state](#), based on data that plans submitted to Healthcare.gov.¹⁴ HHS included the three largest federal employee plans with this list. State human resources officials should be able to name the three largest state employee plans. The state insurance department may have information on the largest non-Medicaid HMO; if not, a data request to insurers may be needed.

Figure 1





The HHS study found limited coverage by potential benchmark plans in some types of coverage that are important for children.

Comparing and Choosing a Benchmark

Once the benchmark choices are identified, stakeholders will want to make sure there is a publicly available comparison of their covered benefits and limitations. [Research released](#) by HHS indicates that, overall, the benefits covered by the benchmark choices are broadly similar—they found that plans vary more in cost-sharing than in covered benefits.¹⁵ Note, however, that the HHS study found limited coverage by potential benchmark plans in some types of coverage that are important for children, including behavioral health treatment, habilitative services, and pediatric oral and vision services. It did not examine coverage for other pediatric services such as those referenced above from the AAP's Scope of Health Care Benefits statement.

Stakeholders thus will need detailed information about the covered benefits and limitations of each of their state's benchmark choices. Insurance

departments in several states have released initial comparisons of benchmark choices, completed either by the state insurance department or contactors:

[Benefits provided by potential benchmark major medical plans](#), Maine (January 2012).

[Essential Health Benefit Benchmark Plan Options](#), Massachusetts (March 2012).

[Washington State Essential Health Benefits Analysis](#) (February 2012).

[Milliman - Essential Health Benefits - Plan Benefit Comparison](#), California (February 2012).

[Preliminary Essential Benefits Analysis](#), Virginia (February 2012).

[Coverage of Essential Health Benefits in Nevada](#) (February 2012).

[Comparison of Benefits in Existing Arkansas Plans](#) (undated).

State Mandates

An additional consideration for states in choosing a benchmark plan is coverage of state insurance mandates. The ACA requires that when a state mandates coverage of services beyond the essential health benefits, the state must “defray the cost” of such mandates by making payments to insurers or to individuals. The Bulletin, though, provides a mechanism for states to avoid paying for many mandates. By selecting a benchmark plan that already complies with existing state mandates, those existing mandated benefits are automatically included in the state's EHB. Thus, the mandated benefits do not go beyond the EHB and are not subject to payment by the state. The Bulletin also clarifies that a state may not add a benefit mandate after December 31, 2011 and have it included in its EHBs.

States, then, have a strong incentive to choose a benchmark plan that is subject to state mandates. Notably, though, not all state mandates may be covered by one of the benchmark choices—mandates that apply in the individual market but not the small group market would not be included by any of the benchmark choices. Further, mandated benefits may be included in benchmark choices even if they are not subject to the state mandates. For instance, federal employee plans cover many of the benefits states most commonly mandate, even though they are not required to by law. So determining which mandates are included by the benchmark choices may require close analysis.

[A brief prepared by the Center for Studying Health System Change](#) provides useful information on state mandates and the essential health benefits. It analyzed the potential costs that one state—Maryland—would need to defray due to benefit mandates under different EHB benchmark choices. It found potential costs for the state in 2016 would range from \$10 million to \$80 million. Because Maryland has several mandates that apply in the individual market but not in the small group market, it found that the highest cost was associated with choosing a small group benchmark plan while the lowest was with the HMO benchmark. Other states would have different results based on the application of their benefit mandates—stakeholders should examine state mandates carefully as they consider a benchmark plan.



Comparisons like these are helpful starting points, but they typically label an entire coverage category as either covered or uncovered without detailing specific coverage limits (although the Washington document does include a section on limits). **Advocates should press for as much detail as possible--they should work to make sure insurance regulators make public a detailed comparison of each benchmark choice's coverage and limitations. The public should also have opportunities to comment on the comparison before a benchmark selection is made.**

State officials are expected to choose a benchmark plan by the third quarter of 2012. Several factors are likely to push states toward choosing a small group plan as the benchmark and, in fact, California and Washington have already passed legislation identifying a small group plan as their benchmark choices. Because EHBs apply to the individual and small group markets, insurers make the case that an existing small group benchmark may minimize “disruption” in a state’s insurance markets. Small group plans may have more affordable premium costs than other choices. And choosing a small group benchmark automatically includes in the EHBs any benefits that the state mandates insurers provide in that market—see the *State Mandates* box on page 6. Finally, states that do not select a benchmark by the third quarter of 2012 will default to the largest plan in the largest small group product in the state. **Advocates, therefore, should focus their attention on the small group options available in their states.**

Supplementing the Benchmark Plan – Pediatric Services

Choosing a benchmark plan is not the last step in defining a state’s essential health benefits. A state’s benchmark plan must be adjusted, if necessary, to include the ten statutory categories and to prevent discrimination. The Bulletin indicates that when coverage for a certain category is missing, states must look to another benchmark

option and “import” the coverage for the missing category.

While “Pediatric services, including oral and vision care,” is one of the required categories, both the Bulletin and FAQ from HHS seem to interpret this provision to include oral and vision care only. If this interpretation stays in place, the pediatric services category will not guarantee coverage for other services that some children need, like corrective audiology, speech therapy, special diets, and others mentioned in the [AAP Scope of Benefits statement](#) cited above.

In order to assure the inclusion of these kinds of services, more explicit and comprehensive definitions of pediatric services and the other nine categories are needed. Without these definitions, it will be difficult to determine whether the benchmark plan covers the ten categories. For example, does a plan that provides hearing screenings, but not indicated follow-up corrective treatments, adequately cover pediatric services? Must eyeglasses be covered in order to meet the pediatric vision care requirement? Without a definition from HHS in regulation or guidance, states will have difficulty determining whether the benchmark plan needs to be supplemented. It also remains unclear how a state is to proceed if none of the available benchmark options include adequate coverage of a certain category.

Despite this need for further guidance, it is uncertain whether more detailed standards will be provided by HHS before states choose their EHBs. State EHB decision-makers may need to make these determinations for themselves. **If this is the case, state advocates have an opportunity to shape the definitions so that they are beneficial to children and families. They should seek a definition of pediatric services that gives children access to medically necessary care, not only oral and vision services.**

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Securing adequate coverage for children's oral health services may require special attention from advocates.

Many services that are medically necessary for children, such as ambulatory patient services, newborn care, prescription drugs, and chronic disease management are part of the other nine required categories. The inclusion of an additional “pediatric services” category, though, shows that Congress intended children to receive additional services—and these may need to be added to the benchmark plan. Once a benchmark plan is selected, stakeholders should push state officials to continue the EHB selection process by determining whether the benchmark plan’s benefits must be supplemented. For pediatric services, advocates should ask for an examination of the benefits in each of the other nine categories to determine whether children need a benefit that is different or greater than those defined for adults (again, see the [AAP’s Scope of Benefits](#)). Advocates should ask the state to explain how this analysis was completed and show how the “pediatric services” category has been fulfilled.

Pediatric Dental Benefits

The oral health services component of pediatric services may be a particular concern for child advocates. Coverage of pediatric dental benefits is uneven among potential benchmark plans, since most dental coverage today is offered separately from medical insurance. The Bulletin suggests that when a benchmark plan does not include coverage for pediatric dental benefits, a state will have the option of supplementing its benchmark with either the largest federal employee dental plan or the state’s separate CHIP dental benefit. (The eleven states and the District of Columbia without a separate CHIP program may establish a benchmark benefit that is consistent with CHIP standards.) Advocates should check their state’s CHIP dental benefit to determine whether it is a good choice for use in the EHBs. It should be compared to the alternate choice, the Federal Employees Dental and Vision Insurance Program (FEDVIP) [MetLife High option](#).

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advocates. Many existing dental benefit plans rely on relatively low annual dollar limits on coverage. The ACA prohibits dollar limits for exchange plans, so these plans will have to be restructured to comply. Advocates should push for benefits that meet children’s needs and oppose those that establish strict limits on coverage that could serve as a dollar limit by another name. One promising model that assures children can access the care they need while limiting expenditures for unnecessary care is known as a risk-based pediatric dental benefit. For more on this type of benefit, see [this memo from the Children’s Dental Health Project](#).¹⁶

Advocates should also note that while pediatric dental benefits are required to be part of the EHBs, in exchanges they may be offered through stand-alone plans separate from the plans that provide medical benefits. When stand-alone pediatric dental plans are offered in an exchange, the medical plans need not provide the pediatric dental EHBs. While beyond the scope of this guide, this provision raises important questions around how benefits and cost-sharing will be coordinated across separate plans each providing part of the EHBs.

Georgetown CCF and the Children’s Dental Health Project have jointly authored an [issue brief](#) that further examines the choices for states on pediatric dental benefits.

Insurer Flexibility

An important consideration for state advocates and other stakeholders is that HHS has indicated insurers will have the flexibility to substitute the coverage of some services within a benefit category, adjust benefit limits, and even potentially remove some of the services under the EHBs and add different ones, as long as the plan remains “substantially equal.” This will greatly complicate the choice of plans for families and may create opportunities for insurers to create plans that discourage those who need certain services from enrolling. If benefits differ by insurer, families will



have to not only judge plans on premium price, cost-sharing, provider network, and any available quality rating, but also compare benefits across plans. Because individuals cannot predict with certainty their own or their children's health needs, this will be a near impossible choice. Parents could choose a plan that excludes a benefit that they only later learn their child needs.

If the option for insurer flexibility remains available under federal regulations, state advocates may still have the opportunity to work to limit it in their states. Through legislation that establishes the essential health benefits or regulation from the insurance department or the exchange board, advocates should work for state rules that limit insurers' flexibility to alter the essential health benefits. For instance, substitutions could be prohibited outright or subject to approval by the insurance regulator. This would give families more confidence that the plan they choose includes the same essential benefits as other plans and that insurers are operating on a level playing field.

Looking Ahead

State advocates have an important opportunity to shape their states' essential health benefits definition. Because of the deadline HHS established in its Bulletin, many states are already studying their benchmark choices and moving to make their EHB selections, so advocates should look to engage right away. At the same time, HHS has not yet proposed formal rules on the essential health benefits, so stakeholders across the country are expecting more direction, both through additional informal guidance and formal rulemaking.

Endnotes

1. New plans are those first offered or significantly changed after the passage of the Affordable Care Act. Older plans are known as grandfathered plans; see more at [Grandfathered Health Plans](#).
2. States have the option of providing benchmark or benchmark-equivalent coverage to certain categories of Medicaid enrollees under section 1937 of the Social Security Act. Beneficiaries newly eligible under the Affordable Care Act are required to be provided benchmark benefits. This use of "benchmark" in Medicaid should not be confused with the overlapping but separate set of benchmark plans that states will use as the basis for their essential health benefits.
3. Chapin White and Amanda E. Lechner, State Benefit Mandates and National Health Reform National Institute for Health Care Reform Policy Analysis No. 8, February 2012.
4. Genevieve M. Kenney, et al., [Improving Coverage For Children Under Health Reform Will Require Maintaining Current Eligibility Standards For Medicaid And CHIP](#), Health Affairs, December 2011.
5. Kenney 2011.
6. Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin, December 2011.
7. The categories are: (A) Ambulatory patient services; (B) Emergency services; (C) Hospitalization; (D) Maternity and newborn care; (E) Mental health and substance use disorder services, including behavioral health treatment; (F) Prescription drugs; (G) Rehabilitative and habilitative services and devices; (H) Laboratory services; (I) Preventive and wellness services and chronic disease management; (J) Pediatric services, including oral and vision care.
8. HHS began to address cost-sharing for subsidized exchange enrollees in a [February 2012 Bulletin](#) and further guidance and regulation is expected.
9. American Academy of Pediatrics Committee on Child Health Financing, Scope of Health Care Benefits for Children From Birth Through Age 26, Pediatrics Vol. 129 No. 1, January 1, 2012, pp. 185-189.
10. Centers for Medicare & Medicaid Services, Frequently Asked Questions on Essential Health Benefits Bulletin, February 2012.
11. HHS has defined product as a general set of benefits, often associated with a specific provider network. Multiple plans may be offered within a product so that small businesses can choose a tailored set of benefits. The largest of these plans by enrollment is the one that may be an EHB benchmark.
12. When a state does not make an EHB choice and the default plan is missing a required benefit category, supplemental benefits will come from the other benchmark choices in an order specified in the HHS FAQ.
13. A separate EHB benchmark applies in Medicaid. HHS has clearly stated that the state Medicaid agency must choose this benchmark.
14. Center for Consumer Information and Insurance Oversight, Essential Health Benefits: List of the Largest Three Small Group Products by State, July 2012.
15. Laura Skopec, et al., Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans, Assistant Secretary for Planning and Evaluation Research Brief, December 2011.
16. Children's Dental Health Project, Recommendations for Essential Health Benefits Package, December 2011.

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