Penn LDI Leonard Davis Institute of Health Economics

Robert Wood Johnson Foundation

Essential Health Benefits: 50-State Variations on a Theme

In-Brief

All qualified health plans under the Affordable Care Act must cover a package of essential health benefits (EHBs) equal in scope to a typical employer plan. The law laid out 10 general categories of services that EHBs must cover, but did not itemize those services. As an interim policy for 2014 and 2015, the Department of Health and Human Services allowed each state to identify an existing plan as a benchmark for these EHBs. The result of this policy is that EHBs vary from state to state, often because of a legacy of different state-mandated benefits (such as treatments for autism, infertility, or temporomandibular joint disorders). This Data Brief analyzes state variation in coverage and limits for these non-uniform benefits.

Before the Affordable Care Act (ACA), no national standard defined a core set of benefits that should be provided by health insurance plans. States had widely varying mandates on specific services, providers, or populations that had to be covered, and on whether the mandates applied to plans sold on the individual, small-group, or large-group market. Self-insured plans were generally exempt from state mandates because they are governed by federal ERISA rules. State mandates were often the result of protracted political battles by advocacy groups and have been criticized for adding to premiums and reducing the affordability of coverage. However, the marginal costs of most state-mandated services are less than 1%, and their collective impact on premiums is generally less than 5% (see, for example, this Maryland analysis). Nevertheless, state mandates rarely reflect systematic decisions about the value and effectiveness of a particular service.

The ACA was supposed to change that. It required that new plans sold on the individual market or to small groups include a package of "essential health benefits (EHBs)" that covered 10 broad 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; and (10) pediatric services, including oral and vision care. It directed the Secretary of the Department of Health & Human Services (DHHS) to specify the exact nature of the essential benefits package.

For both political and practical reasons, DHHS chose to allow states to define their own EHBs in 2014 and 2015 by picking an existing benefits package offered by one of a number of "benchmark plans" in the state. States could choose among the following benchmarks:

- one of the three largest plans, by enrollment, in the state's small-group market;
- one of the state's three largest state employee plans;
- one of the three largest Federal Employees Health Benefit Program options;
- the state's largest non-Medicaid HMO.

If the state did not choose, the default plan would be the largest small-group plan in the state. The benchmark plan's benefit package is taken as a whole, although plans could substitute an "actuarially equivalent" service within a given category. Most benchmark plans did not have coverage for three required categories: habilitative services, and pediatric oral and vision care. DHHS provided separate guidance on how states could augment their benchmark plans to cover these services.

States had an incentive to pick (or default to) a small-group plan, because that allowed states to incorporate the vast majority of their mandated services into their EHBs, at least for 2014 and 2015. This was important because the ACA requires states to defray the costs of state-mandated benefits that exceed EHBs in qualified health plans (QHPs).

Thus, EHBs in states in 2014 and 2015 are a product of 1) the state mandates in place in 2011 [prior to the ACA] and 2) the choice of a benchmark plan. While all EHBs include the 10 broad categories, they also include various state-mandated benefits, creating benefit packages that vary by state. This Data Brief reviews the choices each state made for a benchmark plan, and highlights some of the benefits that are not uniformly covered or are covered differently across states.

STATE CHOICES OF BENCHMARK PLANS

The following map displays each state's benchmark plan choices. Twenty-five states defaulted to the largest small-group plan in the state; 20 states and DC chose one of the small-group plans; two states chose a state employee plan; and three chose the largest HMO. None chose a federal employee plan.

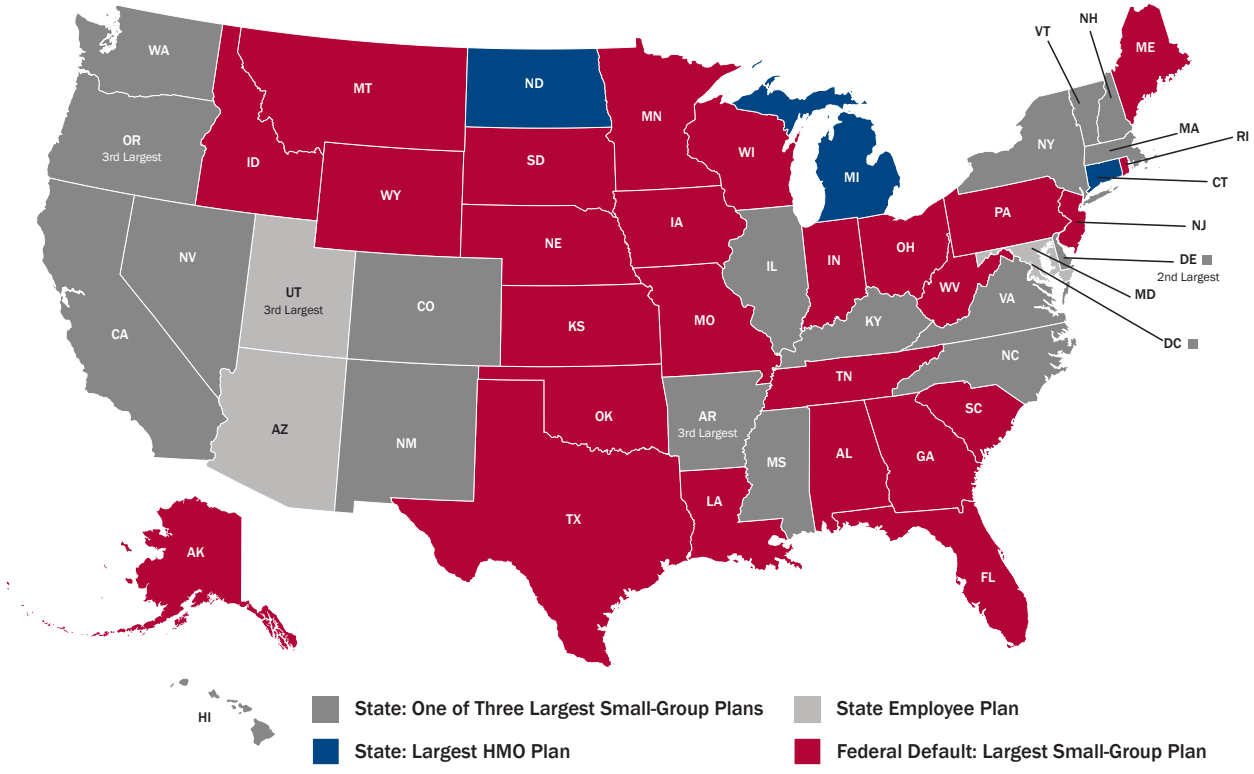
It is not surprising that 45 of 50 states have a small-group benchmark. Choosing a federal plan could have exposed the state to extra costs if a state-mandated benefit were not in the plan; alternately, the federal plan could have included benefits not generally available in the state's individual or small-group market. By choosing a benchmark plan that included state-mandated benefits, a state could avoid financial exposure, or the political ramifications of repealing existing state mandates.

Many of the states that chose a benchmark relied on actuarial analyses to assess the impact of each option on coverage of state-mandated benefits. The three states choosing their largest HMO as a benchmark did so after analyses showed that the option would cover all state-mandated benefits. Analyses in ND and MI concluded that the HMO was the least expensive alternative; in contrast, CT chose the HMO as a compromise between the "too generous" state employee plan and the "too restrictive" small-group plan in terms of several non-uniform benefits.

WHAT WE DID

The majority of data used in this brief was collected from the CMS Revised Benchmark Benefits Worksheet published May 22, 2014. This data set contained a collection of state-specific worksheets detailing essential health benefits, state required benefits, quantitative limits on benefits and other general coverage information for all 50 states and the District of Columbia. These worksheets were compiled to create summary data sets in order to compare the quantity of benefits covered between states and the rates of coverage by benefits. Summary statistics were calculated based on these compiled sets to allow for comparisons. We focused on 11 of the non-uniform services across EHBs, many of which were the subject of different state mandates. One frequent target of state mandates—Autism Spectrum Disorder (ASD)—was not systematically included in

State Essential Health Benefit Benchmark Plans



Source: Centers for Medicare and Medicaid Services

the CMS worksheets. To supplement, we gathered data on EHB coverage from Autism Speaks, an advocacy group monitoring the issue. We were unable to systematically identify the quantitative limits set on autism coverage, although many states had these limits prior to the ACA. We compiled data on five other services with highly variable quantitative limits, including three that were uniformly covered in all EHBs: hospice, home health, and outpatient rehabilitation.

WHAT WE FOUND

The interim policy that defined EHBs by benchmark plans resulted in benefit packages that varied considerably across states. On one hand, chiropractic care was most frequently included (45 states). On the other hand, acupuncture was rarely included (5 states). CA was an exception, because it included acupuncture in its EHBs but not chiropractic care. Just 20 states included routine foot care.

In terms of condition-specific services, 19 states included infertility treatments, 26 states covered autism spectrum disorder, and 31 states covered treatments for TMJ. Even within one condition, the range of services covered varied. For obesity, 23 states included bariatric surgery, but only 12 of them cover nutrition counseling and just three of them cover weight loss programs. Two states (DC and MI) cover the full range of nutrition counseling, weight loss programs, and bariatric surgery.

Autism Speaks identified 25 states and the District of Columbia that include applied behavior analysis in their benchmark plan. This is fewer than the 32 states that had state mandates prior to the EHB determination.

BENEFIT	STATES THAT CONSIDER BENEFIT AN EHB (%)
Chiropractic Care	45 (88%)
Treatment for TMJ Disorders	31 (61%)
Hearing Aids	26 (51%)
Autism Spectrum Disorder Services (including Applied Behavior Analysis)	26 (51%)
Nutrition Counseling	25 (49%)
Bariatric Surgery	23 (45%)
Routine Foot Care	20 (39%)
Infertility Treatments	19 (37%)
Private-Duty Nursing	19 (37%)
Acupuncture	5 (10%)
Weight Loss Programs	5 (10%)

Each state's EHB coverage is detailed below. States cluster into more "expansive" states that cover at least 8 of these services (IL, NM, NV) and less "expansive" ones, covering just one or two (AL, ID, NE, SC, PA, UT).

State	Infertility Treatments	Private-Duty Nursing	Bariatric Surgery	Chiropractic Care	Hearing Aids	Routine Foot Care	Acupuncture	Weight Loss Programs	Treatment for TMJ	Nutrition Counseling	ASD Services
AK				✓			✓				✓
AL	✓			✓							
AR	✓			✓	✓	✓			✓	✓	✓
AZ			✓	✓	✓	✓			✓	✓	✓
CA			✓				✓		✓		✓
CO		✓			✓					✓	✓
CT	✓			✓	✓					✓	✓
DC								✓		✓	✓
DE			✓	✓	✓						
FL				✓		✓			✓		
GA	✓			✓					✓		
HI	✓		✓		✓					✓	
IA	✓	✓	✓	✓					✓	✓	
ID				✓						✓	
IL	✓	✓	✓	✓	✓	✓			✓	✓	✓

State	Infertility Treatments	Private-Duty Nursing	Bariatric Surgery	Chiropractic Care	Hearing Aids	Routine Foot Care	Acupuncture	Weight Loss Programs	Treatment for TMJ	Nutrition Counseling	ASD Services
IN		✓		✓					✓		✓
KS	✓	✓		✓		✓			✓		
KY		✓		✓	✓				✓		✓
LA		✓		✓	✓	✓				✓	✓
MA	✓		✓	✓		✓		✓			✓
MD	✓		✓	✓	✓		✓		✓	✓	
ME			✓	✓	✓					✓	✓
MI			✓	✓				✓	✓	✓	✓
MN				✓	✓				✓		
MO		✓		✓	✓						
MS				✓		✓			✓		✓
MT	✓			✓		✓		✓	✓		✓
NC	✓	✓	✓	✓	✓	✓			✓		
ND		✓	✓	✓		✓			✓	✓	
NE				✓					✓		
NH			✓	✓	✓	✓			✓		✓
NJ	✓		✓	✓	✓				✓	✓	✓
NM	✓		✓	✓	✓		✓	✓	✓		✓
NV	✓	✓	✓	✓	✓	✓			✓		✓
NY	✓		✓	✓	✓				✓	✓	✓
OH		✓		✓					✓	✓	✓
OK		✓	✓	✓	✓	✓					
OR					✓	✓				✓	
PA				✓							
RI	✓	✓	✓	✓	✓	✓				✓	
SC				✓		✓					
SD	✓	✓	✓	✓					✓		
TN				✓	✓				✓	✓	
TX				✓	✓	✓			✓	✓	✓
UT										✓	
VA		✓		✓					✓	✓	
VT		✓	✓	✓		✓				✓	✓
WA				✓	✓	✓	✓		✓	✓	
WI				✓	✓				✓		✓
WV		✓	✓	✓					✓		✓
WY	✓	✓	✓	✓							

QUANTITATIVE LIMITS OF COVERAGE

The ACA prohibits annual or lifetime dollar limits on EHBs. However, states that had mandates with dollar limits could impose non-monetary limits on services that were actuarially equivalent to the dollar limit.

States varied considerably on whether they imposed quantitative limits of services, and on the range of episodic, yearly, or lifetime limits if they did so. For example, all states cover home health as an EHB, but 31 limit coverage to an average of 83.6 days/visits per year, ranging from 30 days/visits in OK and UT to 180 days/visits in MT. Similarly, all states cover outpatient rehabilitation, but 11 states impose limits ranging from 20 visits per year in MS and WY to 60 visits per year in AZ and NV. All states cover hospice services, but 10 states limit coverage in a variety of units, from 14 days per lifetime in WA, 30 days per year in MN, 210 visits per year in NY, 6 months per episode in SC, and 6 months per lifetime in MS. Of the 48 states that cover skilled nursing facilities as an EHB, 37 impose a limit that averages 74 days per year or benefit period, with a range from 25 days in TX to 200 days in NY.

Of the states including chiropractic care, about half impose limits that average 18.6 visits per year, with a range of 10 visits in WA and 40 visits in ME. Interestingly, two states report dollar limits on chiropractic care ($600 per year in AL, $1,000 per year in IL), although those limits cannot be applied to EHBs under the ACA.

POLICY IMPLICATIONS

By design, EHBs vary from state to state in the first two years of the ACA. DHHS chose this strategy to take advantage of existing benefit plans and pricing in the states and to avoid a potentially long and difficult negotiation to define one national benefits package. DHHS has said that it will re-evaluate this strategy for 2016.

This brief describes some of these differences, often a legacy of the many state insurance mandates fought for, and won, in state capitals. This is a far less viable strategy for expanding coverage now, since no mandates passed beyond 2011 are considered EHBs.

In 2011, the Institute of Medicine (IOM) recommended a process for establishing a single national benefit package. It focused on selecting services based on medical effectiveness and affordability, rather than simply including state mandates. These recommendations have yet to be implemented.

The range and scope of services included in EHBs directly affect the affordability of coverage in the individual and small-group market. On the one hand, some might argue that the market has determined this trade-off in each state, and that the benefit package in the benchmark plan fairly represents EHBs as reflected in a typical employer plan. On the other hand, others might argue for a more comprehensive approach that uses consistent criteria and methods to determine uniform EHBs in all states. For now, some benefits will remain essential in some states, and not essential in others.

BENEFIT (STATES THAT COVER BENEFIT)	STATES W/QUANTITATIVE LIMIT ON BENEFIT	AVERAGE LIMIT OF DAYS/VISITS PER YEAR OR BENEFIT PERIOD (RANGE)
Skilled Nursing Facility (48)	37	74.1 (25-200)
Home Health (51)	31	83.6 (30-180)
Chiropractic (45)	27	18.6 (10-40)
Outpatient Rehab (51)	11	35.9 (20-60)
Hospice (51)	10	N/A

About the Authors

This Data Brief was written by Janet Weiner, MPH, and Christopher Colameco.

About The Leonard Davis Institute of Health Economics

The Leonard Davis Institute of Health Economics (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

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