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Essential Health Benefits in Texas

WHAT ARE "ESSENTIAL HEALTH BENEFITS?"

Essential health benefits are a new "floor" for insurance coverage created by the Affordable Care Act to ensure that health insurance policies cover a comprehensive range of health care services. Essential health benefits will take effect in 2014.

WHY ARE ESSENTIAL HEALTH BENEFITS IMPORTANT?

Today some health insurance policies, especially those sold directly to individuals (not through an employer) and to small businesses fail to cover necessary benefits, such maternity coverage, mental health care, and prescription drugs. Beginning in 2014, the Affordable Care Act will require that a basic standard of care be met by most insurance plans,

What services must be covered as an essential health benefit?

The Affordable Care Act requires that the scope of the essential health benefits be equal to the "typical employer plan" and include 10 categories of services:

- Ambulatory Patient Services,
- Emergency Services,
- Hospitalization,
- Maternity and Newborn Care,
- Mental and Behavioral Health Services, including Drug Treatment,
- Prescription Drugs,
- Rehabilitative and Habilitative services and Devices,
- Laboratory Services,
- Preventive and Wellness services and Chronic Disease Management, and
- Pediatric Services including Dental and Vision Care.

WHICH INSURANCE PLANS MUST COVER ESSENTIAL HEALTH BENEFITS BEGINNING IN 2014?

These benefits must be covered in all plans sold directly to individuals (not through an employer) and to small businesses (with up to 50 employees). Medicaid coverage offered to newly eligible adults in 2014 must also include essential health benefits.

HOW MUCH WILL PLANS WITH ESSENTIAL HEALTH BENEFITS COST?

Premiums will depend largely on how much out-of-pocket "cost-sharing" (deductibles, copayments, and coinsurance) is required in the plan you choose. In 2014, all plans sold to individuals and small businesses will be assigned a "metal tier" that indicates on average how much the insurance company will cover. Platinum plans will cover 90% of the cost of medical services, on average,

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with the enrollee paying 10% through out-of-pocket cost-sharing. Gold plans will cover 80%, silver 70%, and bronze 60%. Regardless of what metal tier a consumer chooses, the same EHBs will be covered in each plan.

HOW ARE THE SPECIFICS OF THE ESSENTIAL HEALTH BENEFITS PACKAGE FOR COMMERCIAL COVERAGE DETERMINED AT THE STATE LEVEL?

States have the flexibility to determine both the specific services covered and benefit limits imposed by the essential health benefits. States will do this by selecting one of ten existing plans in the insurance market to serve as the essential health benefits benchmark for plans sold to individuals and small businesses. Options include:

- Any of the 3 largest small employer plans by enrollment,
- Any of the 3 largest state employee plans by enrollment,
- Any of the 3 largest federal employee plans by enrollment, or
- The largest commercial HMO in the state.

The benchmark must cover all ten benefit categories listed in the Affordable Care Act, or be supplemented so that all categories are covered.

WHAT IF A STATE DOES NOT SELECT A BENCHMARK?

If a state does not act to select an essential health benefits benchmark plan, the benchmark will automatically become the largest small employer plan in the state.

WHAT IS THE TIMELINE FOR SELECTING THE ESSENTIAL HEALTH BENEFITS BENCHMARK?

Texas must select and supplement its essential health benefits benchmark plan by the end of September 2012. If Texas does not make a decision by then, the benchmark will default to the largest small employer plan in the state.

WHICH PLAN WILL TEXAS CHOOSE?

At this point, state and federal agencies are still working to identify the 10 benchmark options that Texas can choose from. Future federal guidance will likely provide more information on how a state can select a benchmark. It is not yet clear what Texas' process will be to select a benchmark and whether or how the public can participate in the process.

WHAT IF THE BENCHMARK PLAN THE STATE CHOOSES DOESN'T INCLUDE ONE OF THE REQUIRED BENEFIT CATEGORIES?

If a state chooses a benchmark plan that excludes one of the 10 required categories of services, the state must supplement benefits for that category with the benefits provided by another benchmark option.

WILL INSURERS HAVE FLEXIBILITY TO SELL POLICIES WITH DIFFERENT BENEFITS THAN THE ESSENTIAL HEALTH BENEFITS BENCHMARK?

The federal government has proposed that insurance companies must cover benefits that are "substantially equal" to the benchmark. Insurers may be granted

the flexibility to remove some benefits found in the benchmark if they add alternate benefits of equal value. Advocates are concerned that this flexibility will make it difficult for consumers to make apples-to-apples comparisons between plans. Additionally, insurers could take advantage of this flexibility to remove benefits valued by less healthy enrollees and add benefits valued by healthier enrollees as a way to try to avoid covering sick individuals (remember that in 2014, insurance companies will no longer be able to deny coverage to sick individual or charge them more).

HOW DO STATE-LAW MANDATED BENEFITS RELATE TO ESSENTIAL HEALTH BENEFITS?

All states mandate that health insurance plans sold within the state contain certain benefits. States must cover the costs of any state-mandated benefits that exceed the benefits offered in a state's essential health benefit benchmark. If a state selects a benchmark plan that includes some mandated benefits, like the small employer plan options, then the essential health benefits will automatically incorporate those mandates, reducing the potential cost to the state.

WHAT ARE STATES DOING?

States have several tasks to complete: forming workgroups, identifying their 10 benchmark options, analyzing the plan differences, analyzing existing state benefit mandates, accepting public comment, and selecting and supplementing an essential health benefits benchmark plan. Texas has not publicly moved forward on any of these steps yet, but other states have. Some examples include: Maryland and Rhode Island have designated essential health benefit workgroups. Michigan and Maine have prepared summary comparisons of benchmark options for the public and decision makers. Washington and Virginia have contracted with consultants to do in-depth analyses of the tradeoffs between benchmark options. California and Washington have passed legislation establishing their benchmarks. The task force charged with selecting Oregon's benchmark has made a preliminary recommendation and is accepting public comment. Virginia and Michigan have also accepted public comments on their benchmark options.

More Information

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