Essential Health Benefits & the Affordable Care Act:
What Social Workers Need to Know

Summary
A component of the Patient Protection and Affordable Care Act (ACA) will have a direct impact on the health and well-being of over 70 million Americans. Beginning in January 2014, most individual and small group health plans operating in the U.S. will be required to provide “essential health benefits” (EHB), a package of health services defined broadly by the ACA, but customized by each state. Social workers should be aware of the EHB development process in their states, to ensure that their state EHB plan addresses the needs of people with chronic disease, disabilities, and other complex health issues, including individuals with mental health and substance use disorders, and that access to social work services is maintained and strengthened.

What is the EHB Process and Why is it Important?
The individual and small group insurance markets in the U.S. have traditionally offered the most expensive—and most inadequate—coverage of all commercial health plans. The ACA addresses this problem through the EHB process. The ACA outlines ten broad categories of essential health benefits (see chart) deemed essential for all Americans. The ACA delineated these benefit categories to assure consumers and small businesses that health insurance plans purchased beginning in 2014 will be comprehensive, providing key services at appropriate levels to address serious health conditions (Greenwood et al., 2012). Certain benefit categories, such as rehabilitative and habilitative services and treatment for mental health and substance use disorders, are particularly important for individuals with disabilities or chronic conditions, many of whom will be newly insured through the state health exchanges and the Medicaid expansion. However, these benefits are often poorly covered or absent in traditional small group insurance plans.
Federal regulation requires each state to select its own EHB plan, known as a benchmark plan, which must be inclusive of all ten benefit categories. Ultimately, over 70 million people, both currently insured and newly insured through the ACA, will have health benefits defined by the EHB.

How does the state EHB process work?

First, each state must select a benchmark plan from one of the following four insurance groups:

- Any of the largest three plans (by enrollment) in the state’s small group insurance market
- Any of the largest three state employee health benefit plans (by enrollment)
- Any of the largest three national federal employee health plans (by enrollment)
- The largest commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

Then states must review the plan for adherence to the ten mandated benefit categories. If a benchmark plan does not include all ten benefit categories, the state must provide supplemental coverage to fulfill the requirement. A state’s benchmark plan serves as the basis for all health insurance plans offered by the following entities:

- State exchanges (the new online insurance marketplaces, also authorized by the ACA, in which individuals and small businesses can shop for coverage)
- All small group and individual plans operating outside of the state health exchange
- All plans offered to newly eligible beneficiaries in the Medicaid expansion outside of the state health exchange
- Plans offered to newly eligible beneficiaries in the Medicaid expansion population.

Self-insured and large group health plans are not required to comply with the state’s benchmark plan. All benchmark plans must ultimately be approved and certified by the Department of Health and Human Services (HHS).

According to the ACA, each state was required to communicate its selected benchmark plan to HHS by September 30, 2012. As of that date, 21 states and the District of Columbia had chosen a plan. HHS has indicated it will accept state benchmark plan submissions beyond the September 30, 2012 deadline. If a state does not select a benchmark plan, the largest plan in the small group market will be the state’s benchmark plan by default. Before final approval and certification of the state benchmark plans, HHS will offer an opportunity for public comment on all the proposed state plans.

Ten Essential Health Benefit Categories

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Mental health and substance use disorder services, including behavioral health treatment

What is needed to ensure appropriate coverage in the benchmark plans?

Proposed state benchmark plans should be reviewed carefully to ensure comprehensive coverage for all enrollees, especially those with disabilities or chronic conditions, and appropriate adherence to the mandated benefit categories. NASW and other advocates have developed the following recommendations for state benchmark plans:

- **MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT**
  - Robust mental health and substance use disorder treatment is critical to prevent the development of co-occurring chronic diseases and costly inpatient hospitalizations. Plans should offer access to the full range of effective services, including prevention, treatment, rehabilitation, and recovery services. With regard to treatment, special attention should be given to medication-assisted therapies, residential services, and chronic disease management programs. Plans should demonstrate strong network adequacy, including access to clinical social work services.

- **AMBULATORY PATIENT SERVICES**
  - Regular access to healthcare providers with the appropriate experience and expertise is a key component of care for people living with chronic illness. Plans should offer people living with chronic conditions access to disease-appropriate specialty services without visit limits.

- **PREVENTIVE AND WELLNESS SERVICES**
  - Although the ACA requires health plans to include all preventive services with an A or B rating from the United States Preventive Services Task Force, plan details should be read carefully, to ensure inclusion of important services such as well-woman visits, domestic violence screening, and contraception. In addition, case management and care coordination should be a required chronic disease management service for benchmark plans.

- **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES**
  - Essential rehabilitation and habilitation care should include services and devices that improve, maintain, and lessen the deterioration of a patient’s functional status over a lifetime and on a treatment continuum (Coalition to Preserve Rehabilitation, 2012). Because many insurance plans do not currently provide habilitative services and devices, special attention should be given to ensure that any supplemental coverage for this benefit category meets the care and treatment needs of people living with chronic conditions and disabilities. Medicaid provides a good guide for determining specific benefits for inclusion in this category. In addition, because of the conditions that require this category of services, it is critical that medical necessity determinations for rehabilitative and habilitative services and devices are based on clinical judgment and not arbitrary limits or caps.

- **PRESCRIPTION DRUGS**
  - People living with chronic conditions often require access to a range of prescription medications to effectively manage their conditions and stay healthy. The HHS proposal to require plans sold through state exchanges to cover at least one drug per class will not ensure access to essential medications and is at odds with the nondiscrimination and access provisions of the ACA. Other federal requirements regarding prescription drug access—for instance, the Medicare Part D policy requiring plans to cover all of the medications in six protected classes—offer a better approach to ensure access to these vital benefits. At the very least, the prescription drug coverage of the benchmark plan chosen in the state is often more robust than the one drug per class floor articulated in the HHS guidance. There should be a floor for prescription drug coverage.

**STATE-MANDATED BENEFITS**

Prior to passage of the ACA, many states already had mandated coverage for selected benefits. Such state-level mandates vary widely across the nation. The ACA does not directly preempt existing mandates, but does require states to pay the costs of state-mandated benefits that are not included in the ten essential benefit categories. For example, autism treatment, which is mandated in 30 states, might be assumed to be included in habilitative or behavioral health coverage for all enrollees, especially those with disabilities or chronic conditions, and appropriate adherence to the mandated benefit categories.
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Self-insured and large group health plans are not required to comply with the state’s benchmark plan. All benchmark plans must ultimately be approved and certified by the Department of Health and Human Services (HHS).

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Mental Health and Substance Use Disorder Treatment
Robust mental health and substance use disorder treatment is critical to prevent the development of co-occurring chronic diseases and costly inpatient hospitalizations. Plans should offer access to the full range of effective services, including prevention, treatment, rehabilitation, and recovery services. With regard to treatment, special attention should be given to medication assisted therapies, residential services, and chronic disease management programs. Plans should demonstrate strong network adequacy, including access to clinical social work services.

Ambulatory Patient Services
Regular access to health care providers with the appropriate experience and expertise is a key component of care for people living with chronic illness. Plans should offer people living with chronic conditions access to disease-appropriate specialty services without visit limits.

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Although the ACA requires health plans to include all preventive services with an A or B rating from the United States Preventive Services Task Force, plan details should be read carefully, to ensure inclusion of important services such as well-woman visits, domestic violence screening, and contraception. In addition, case management and care coordination should be a required component of care for benchmark plans.

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**Benchmarks Plans and Parity**

The ACA includes strong non-discrimination language to ensure that plans sold through the exchanges do not discriminate against people with chronic and complex conditions. The law further mandates that benefit coverage is appropriately balanced among the categories of covered benefits. Additionally, all EHB plans should include coverage for mental health and substance use disorders at parity with medical/surgical benefits. Nevertheless, benchmark plans need to be reviewed closely for adherence to parity and nondiscrimination rules. Ultimately, strong federal oversight will be needed to ensure that people with chronic illnesses or disabilities who enroll in the exchanges are protected from discrimination and gain meaningful access to care and support.

**Opportunities for Social Work Involvement in the EHB Selection Process**

**OFFER YOUR KNOWLEDGE OF YOUR STATE’S POTENTIAL BENCHMARK PLANS**

Contact local health reform advocates and find out if your state is engaged in a benchmark plan selection process. If so, review the plans under consideration (some state benchmark information is posted on this website: www.statereforum.org/state-progress-on-essential-health-benefits). Offer your perceptions of and experiences with the potential benchmark plans. **COMMENT ON YOUR STATE’S SELECTED BENCHMARK PLAN**

It is vitally important for social workers and other advocates to review state benchmark plans carefully and provide feedback to HHS. Concern has already been expressed about shortcoming in benchmark plans submitted to HHS and the high degree of variability among state plans (Kliff, 2012). For example, the state of Utah has chosen a benchmark plan that offers no coverage for inpatient or outpatient substance use treatment or autism therapy, and a maximum of eight visits per plan year for mental and behavioral health outpatient services (NASHP, 2012). By contrast, New York’s proposed EHB plan covers these services, and offers 30 visits per plan year for mental and behavioral health outpatient services (NASHP, 2012).

It is projected that by December 2012, HHS will announce the 51 selected benchmark plans and request public comment on them. As HHS is charged with certifying each benchmark plan, the public comment process will give stakeholders, including social workers, an opportunity to review the plans and provide comment to HHS, using the criteria specified above. NASW will further update members when the HHS announcement is made.

**Conclusion**

The EHB process is a critical component of the Affordable Care Act. By establishing EHB plans that offer adequate and appropriate benefits, states have an opportunity to greatly enhance health insurance coverage for millions of Americans who are uninsured or underinsured, particularly people with disabilities and other vulnerable populations.

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