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The ACA and Essential Health Benefits: Overview of the New Coverage Standards in the Individual and Small Group Markets

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Beginning in January 2014, the Affordable Care Act (ACA) introduced a series of health insurance reforms, particularly for consumers purchasing coverage through the individual market or covered through employment at a small firm. One of the most prominent of these reforms is the requirement that all health plan products in certain market segments must cover an established set of essential health benefits (EHBs). EHBs create a minimum standard for insurance coverage; however, because many health plan products often lacked benefits for certain services, implementation was lengthy, involving federal regulators, state agencies, private insurers, and consumers.

The EHBs are an important element of the health insurance marketplaces, also known as exchanges, which were created by the ACA and launched by the federal government and states to facilitate the purchase of qualified health plans (QHPs) by individuals, families, and small businesses, with financial assistance for those who qualify. This brief discusses how EHBs were defined and implemented, what plans must cover them, and how this has changed the insurance market. An analysis of the implementation process in Michigan is also provided.

Essential Health Benefits Requirements

The ACA mandated that non-grandfathered[1] individual and small group health plans (both on and off the marketplaces) cover a minimum set of essential health benefits to make coverage more equivalent to that of a "typical employer plan."[2] The set of benefits must include services from the following ten categories, as defined by the ACA:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory service
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

Health plans were permitted to cover services beyond those included in the ten categories, but under two conditions: (1) Separate premiums must be collected for any covered abortion services and no premium tax credits or other federal funding can be used to cover those services. (2) If a state law requires services in addition to the EHB categories to be covered, the state must pay any additional costs for those benefits for consumers purchasing coverage on the marketplace.

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As displayed in Figure 1, the ACA only requires non-grandfathered individual and small group health plans (sold on and off the marketplaces) to cover EHBs. Small group is defined as an employer with 50 or fewer full-time equivalent (FTE) employees, but this definition will be expanded to groups with 100 or fewer FTE employees in 2016. While this excludes the majority of those with private insurance who receive coverage through a large employer, most large employers already provide coverage for EHBs.

FIGURE 1. Health Plans Required to Cover Essential Health Benefits, By Market Type[3]

Health Plans by Market Type			Required to cover EHB
Private Plans Sold on Marketplaces		Small Group	Yes
		Individual	Yes
Private Plans Not Sold on Marketplaces	*New Plans*	Self-insured	No
		Large Group	No
		Small Group	Yes
		Individual	Yes
	Grandfathered Plans	Self-insured	No
		Large Group	No
		Small Group	No
		Individual	No
Public Plans		Medicaid Non-Benchmark Coverage	No
		Medicaid Benchmark or Benchmark-Equivalent Coverage	Yes
		Basic Health Plan	Yes
		Medicare	No

While this issue brief focuses on the private market, EHB requirements also extend to certain Medicaid eligibility categories. This means that those who are newly eligible for Medicaid will receive benefits similar to those of people who enroll in a plan through the marketplaces. This is an important consideration, as millions of Americans are expected to experience income changes from year to year, which will shift their program eligibility from Medicaid to the individual marketplace or vice versa.[4]

EHB Implementation through Federal Regulations

Following passage of the ACA, the U.S. Department of Health & Human Services (HHS) was charged with determining which services would be included in each of the ten EHB categories. HHS chose to seek input from several sources to help inform its definition, which would be the foundation for how much individual and small group health plans would cost in 2014 and 2015.

To begin, the U.S. Department of Labor conducted research for HHS on the coverage offered by employer plans. HHS then held public forums across the country to gather public input, and asked the Institute of Medicine (IOM) to recommend a process that would help define and update the EHB package. HHS requested that the process take into account the cost impact of any benefit changes, as every added service would increase cost.[5] In October 2011, IOM submitted its report to HHS. The report emphasized the importance of affordability when defining and updating the benefits and made several recommendations; including recommendations that the EHB package should

- reflect plans in the small group market to lessen the market impact,
- balance cost with the comprehensiveness of services, and
- be updated annually beginning in 2016.[6]

Many expected HHS to define a national minimum standard.[7] However, in December 2011, HHS published a bulletin, later codified via the regulation process, that established a state-by-state standard. The bulletin requested that each state select an EHB benchmark plan, an existing employer-sponsored health plan in the state that would serve as a coverage starting point. States were asked to select one health plan from the following four categories to serve as the benchmark:[8]

- The largest plan by enrollment in any of the three largest small group products
- Any of the three largest state employee health benefit plans by enrollment
- Any of the three largest national Federal Employees Health Benefit Program (FEHBP) plan options by enrollment
- The largest insured commercial non-Medicaid HMO

If a state did not make a selection by September 30, 2012, the largest small group plan by enrollment would automatically become the state's benchmark. Twenty-five states and the District of Columbia selected a health plan (19 states and DC selected a small group plan, four states selected a commercial HMO, and two states selected a state employee plan) to serve as their benchmark, while 25 states defaulted to the largest small group plan by enrollment.[9]

Not all benchmark plans covered services in every EHB category. HHS directed states to supplement missing benefit categories with the benefits offered by other EHB-benchmark candidates, but some, such as pediatric dental, pediatric vision, and habilitative services, were not offered by any candidate. For these benefit categories, HHS provided states with additional options for defining minimum coverage standards when coverage could not be supplemented with a benchmark candidate.

In addition, HHS decided that insurers could substitute benefits or sets of benefits offered by the benchmark plan as long as the substitutions occurred within the same EHB category (excluding prescription drugs), and the substituted benefits were equivalent in value. States could establish stricter standards for substitution or not allow substitution altogether, but only five states, including Michigan, prohibited substitution.

EHB Requirement and Existing State Requirements

States often mandate individual and small group health plans to cover specific treatments or services. Under the ACA, states are required to fund any premium tax credits or cost-sharing reductions related to state-mandated benefits in excess of the EHB requirement; however, the financial impact of this requirement is expected to be relatively small.[10,11] This is, in part, because many common state mandates are included in the ten EHB categories, including emergency services and prescription drugs.

Further, the benchmark approach taken by HHS allowed states to select or default to a benchmark plan that was likely regulated by the state and already covered any state-mandated benefits. Selecting a benchmark plan that encompassed most or all state-mandated benefits allowed states to reduce or eliminate any financial liabilities during 2014 and 2015.[12]

New and Expanded Coverage

Before the EHB requirement was implemented, individual and small group coverage of habilitative, mental health and substance use disorder, pediatric dental, and pediatric vision services was particularly limited in comparison to the other EHB categories.[13,14,15] The limited coverage for these benefit categories required the federal government and states to take additional steps to establish a complete EHB benchmark, which resulted in some unique implementation features.

Habilitative Services[16]

Unlike the rehabilitative benefit category, there was significant variation in how health plans defined and covered the habilitative benefit category prior to the ACA.[17, 18] The benefit was only "covered" or "covered with limits" by 59 percent of the three largest small group plans in many states (which the majority of states selected or defaulted to as their benchmark).[19] HHS permitted states to determine which services should be included in the habilitative benefit. If a state did not make a determination, it could either: (1) require health plans to cover the same services for habilitative needs as they do for rehabilitative needs and cover them at parity; or (2) allow the insurers to decide which habilitative services to cover and report that information to HHS. HHS is monitoring coverage of habilitative services across the individual and small group markets during 2014 and 2015, and will use the data it gathers from its research to inform future changes.[20]

Mental Health and Substance Use Disorder Services

Traditionally, mental health services have been covered less generously than medical and surgical services. In 2013, HHS estimated that roughly 20 percent of individual market consumers had insurance that did not cover mental health services and one-third had plans that offered no coverage for substance use disorder services; in contrast, 95 percent of consumers with small group plans had some coverage for those services.[21] As part of the EHB package, all non-grandfathered health plans in the individual and small group markets were required to cover mental health and substance use disorder services.[22]

The ACA also requires that individual and small group plans comply with the Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), which requires health plans to ensure that financial and treatment limits on mental health and substance use disorder services are comparable to those placed on medical services.[23] HHS reiterated this requirement via the final EHB regulations, stating that health plans must comply with MHPAEA to fulfill the EHB requirement.[24, 25]

Pediatric Services

Since the EHB-benchmark plans are medical plans, most did not cover pediatric dental or vision services. Of the three largest small group plans in states, about 40 percent offered no coverage options for pediatric dental services and 38 percent offered no coverage options for children's eye glasses.[26] States were able to supplement their benchmark plan by selecting either the state's Children's Health Insurance Program (CHIP), if available, or the Federal Employees Dental and Vision Insurance Program (FEDVIP) plan with the largest enrollment.

Pediatric Dental Services

The ACA treats the pediatric dental benefit much differently than other benefits in the EHB package. During 2014 and 2015, the law allows marketplaces to sell the pediatric dental coverage in three different ways:

- **Embedded dental benefit**: The dental benefit is embedded within a health plan, along with all the other benefits, to create one comprehensive plan.
- **Bundled dental plan**: A separate dental plan is paired with a health plan. The two plans are bundled together and sold as a single product.
- **Stand-alone dental plan:** Consumers select a separate dental plan that is independent from their health plan. This is similar to how dental plans have been traditionally offered.

Some regulations have been applied differently to stand-alone dental plans. These differences have created some confusion and disincentives for purchasing pediatric dental coverage. For example, the premiums for stand-alone dental plans is not factored into the calculation of the premium tax credits and separate out-of-pocket maximums for stand-alone dental plans are stacked upon out-of-pocket spending for medical plans. With 60 percent of U.S. children having cavities or tooth decay by age five,[27] some analysts and advocates have raised concerns that little or no premium assistance for parents to purchase pediatric dental coverage and increased out-of-pocket costs could leave some children without access to dental care.[28,29] Figure 2 provides an overview of how stand-alone, bundled, and embedded dental plans differ.

FIGURE 2. Summary of EHB Pediatric Dental Benefit Offering Options[30]

	Stand-Alone Dental Plans	Bundled Dental Plans	Embedded Dental Plans
Number of states where the plan type is available in 2014	48 states	None (permitted in 5 states and DC, but no plans offered; not allowed in federally facilitated marketplaces in 2014)	47 states and DC
Actuarial Value	Separate dental plans must meet one of the following two actuarial values (plus or minus 2 percent): • High Plans: 85 percent of costs are paid by the dental plan • Low Plans: 70 percent of costs are paid by the dental plan	Separate dental plans must meet one of the following two actuarial values (plus or minus 2 percent): • High Plans: 85 percent of costs are paid by the dental plan • Low Plans: 70 percent of costs are paid by the dental plan	No separate actuarial value guidelines from the metal tiers established for health plans[31]
Out-of-Pocket Maximum	Federally-Facilitated Marketplaces: • 1 child: $700 (2014); $300 (2015) • 2+ children: $1,400 (2014); $700 (2015) State-Based Marketplaces: May set own "reasonable" limits	Federally-Facilitated Marketplaces: • 1 child: $700 (2014); $300 (2015) • 2+ children: $1,400 (2014); $700 (2015) State-Based Marketplaces: May set own "reasonable" limits	No separate out-of-pocket maximum from health plan.
Premium Tax Credits	The benefit is not included in the tax credit calculation for eligible consumers. Consumers are able to apply any remaining tax credit funds to the dental premiums after the funds have been applied to the health plan.	The benefit is included in the tax credit calculation for eligible consumers.	The benefit is included in the tax credit calculation for eligible consumers.

It is important to note that consumers will not be subject to a tax penalty if they do not purchase pediatric dental coverage in 2014 and 2015. Consumers who buy coverage through the marketplaces are not required to buy pediatric dental coverage, [32] while insurers must have "reasonable assurance" that consumers who purchase coverage outside the marketplaces do buy the benefit. Overall, enrollment data for pediatric dental coverage in the marketplace is limited. In May 2014, HHS reported that 63,448 children in 36 states (those with federally facilitated and partnership marketplaces) were enrolled in stand-alone dental plans, but it did not report on how many received dental coverage through embedded plans or how many enrolled in a QHP are without dental coverage.[33]

Pediatric Vision Services

Similar to dental benefits, vision services are traditionally covered by vision plans that are sold separately from medical plans. To meet the EHB standard for pediatric vision services, most states (37) chose the benefit offered by FEDVIP to supplement their benchmark plan, while six states selected the benefit outlined in their CHIP plan. The remaining seven states had selected a benchmark plan that included vision coverage.[34] Pediatric vision benefits covered by both FEDVIP plans and state CHIP plans included vision screenings, an annual comprehensive eye exam if needed, and corrective eyewear (contacts and glasses). The pediatric vision benefit, unlike pediatric dental, must be integrated within the medical plan coverage—allowing the benefit to be included in subsidy calculations.

Michigan and Implementation of Essential Health Benefits

Following the HHS bulletin defining the EHB benchmark selection process, Michigan evaluated its options for 2014 and 2015 over a nine-month period. This involved identifying the ten benchmark candidates, evaluating the variation in benefits among the candidates, determining whether benefits would need to be supplemented, gathering consumer feedback, and deciding whether to recommend a benchmark plan. In September 2012, Michigan chose the Priority Health HMO as its benchmark, supplemented with the MIChild dental plan (for pediatric dental) and the FEDVIP Blue Vision High plan (for pediatric vision).[35]

EHB Benchmark Selection Process

Michigan's EHB benchmark evaluation was led by the Office of Financial and Insurance Regulation (OFIR), which later became the Department of Insurance and Financial Services (DIFS).[36] HHS provided states with the list of the top three small group plans, and OFIR identified the other seven benchmark options using enrollment data from the first quarter of 2012. Figure 3 shows the ten EHB benchmark candidates. If Michigan had not recommended a benchmark plan, it would have defaulted to the small group plan with the largest enrollment (BCBSM Community Blue PPO).

FIGURE 3. Michigan's 2012 Benchmark Candidates

Plan Name	Insurer	Type of Plan	Premium Effect of Benefit Differences[37]
BCBSM Community Blue PPO Plan 4 (*default plan*)	Blue Cross Blue Shield of Michigan	Small Group	$2.00–$2.50
Priority Health HMO	Priority Health	Small Group	$0
BCN10 HMO	Blue Care Network	Small Group	$2.75–$3.50
Priority Health HMO (*recommended plan*)	Priority Health	Commercial HMO	$0
BCBSM Self-Insured	Blue Cross Blue Shield of Michigan	State Employee Plan	$3.50–$4.50

Plan Name	Insurer	Type of Plan	Premium Effect of Benefit Differences[37]
PHP HMO	Physicians Health Plan	State Employee Plan	$4.00–$5.00
Priority Health HMO	Priority Health	State Employee Plan	$2.00–$2.50
FEHBP BCBS Standard Option	Blue Cross Blue Shield Association	Federal Employee Plan	$5.50–$7.00
FEHBP BCBS Basic Option	Blue Cross Blue Shield Association	Federal Employee Plan	$14.50–$18.25
FEHBP GEHA Standard Option	Government Employees Health Association	Federal Employee Plan	$13.00–$16.25

To determine which benchmark candidates could meet federal standards, OFIR grouped the covered benefits of each plan into the ten categories required by the ACA. OFIR also contracted with Wakely Consulting Group to examine the benefit generosity of each candidate and quantify its effect on premium costs. This allowed OFIR to determine the cost effect of its choice and know whether the benchmark selection would need to be supplemented. Wakely's analysis identified the Priority Health HMO as the lowest-cost benchmark option. The default plan would have led to monthly premium costs being $2 to $2.50 greater per person, by comparison (Figure 3). Premium effects for benchmark candidates varied due to benefit differences for covered services, particularly for rehabilitation visits, fertility drugs, and skilled nursing facility days.[38]

Supplementing the Benefits of the Michigan Benchmark Plan

Among the ten benchmark candidates, none provided pediatric vision benefits, and only the federal employee plans provided limited pediatric dental and habilitative benefits. This meant the benchmark plan required supplementation with benefits from other candidates or separate plans. Since the state made its own benchmark selection, it had leeway about how to satisfy all ten categories of essential benefits with its benchmark plan.

Pediatric Dental and Vision Services

Federal guidance provided Michigan with limited options to supplement the benchmark to fulfill the pediatric vision and dental benefit categories. The only vision option was the Blue Vision High plan, the FEDVIP plan with the highest enrollment nationwide. Michigan had two options to supplement pediatric dental benefits: MetLife Dental PPO–High Option, the FEDVIP dental plan with the highest enrollment nationwide, or MIChild dental, the state's CHIP dental plan. Michigan chose MIChild dental, as it had slightly smaller effects on premium costs.

Habilitative Services

Since the Priority Health HMO plan did not provide coverage for habilitative services, OFIR was required to recommend a way to supplement the benchmark plan to include these services. Ultimately, Michigan defined habilitative services[39] and specified applied behavioral analysis (ABA) for the treatment of autism spectrum disorders (ASDs) as a type of habilitative service. Coincidently, in April 2012 Michigan enacted a mandate that most state-regulated plans provide coverage for the diagnosis and treatment of ASDs. QHPs on the marketplace were exempted from this mandate, since it took effect during the benchmark selection process.[40]

In January 2013, however, OFIR issued an order that ABA treatment for autism be included as a habilitative service and required QHP issuers to cover this service in plans offered for 2014.[41] To complicate matters even more, the state law

prohibits visit limits on the treatment of ASDs but allows annual dollar limits, which are prohibited by the ACA. Therefore, insurers were required to convert annual limits to other forms, such as scope or duration limits, for 2014 plans. DIFS later recognized that these limits function similarly to visit limits, which are prohibited by state law, so 2015 plans are prohibited from applying them.[42] Overall, the new autism treatment mandate was originally intended to exempt the QHP marketplace but was ultimately used by the state to satisfy an essential benefit category for plans sold in this marketplace.

2014 Michigan Health Plan Options

In the 2014 Michigan health insurance marketplace, ten insurers offered qualified health plans, and five offered stand-alone dental plans. However, plan competition for QHPs varied significantly by county. In southeast Michigan (Macomb, Oakland, and Wayne Counties), nine insurers offered QHPs, while only one insurer (Blue Cross Blue Shield of Michigan) offered QHPs in Delta County. By comparison, as displayed in Figure 4, three insurers offered dental plans statewide, meaning that all consumers had a choice among a least three companies if they sought to purchase dental coverage through the marketplace.

FIGURE 4: Insurer Participation and Plan Offerings in the 2014 Michigan Marketplace

Insurance Company	Number of Counties Participating	Number of Plans Offered*
Qualified Health Plans		
Blue Cross Blue Shield of Michigan	83	5
Priority Health	70	18
Blue Care Network of Michigan	70	9
Consumers Mutual Insurance of Michigan	47	5
McLaren Health Plan, Inc.	28	6
Health Alliance Plan (HAP)	23	7
Total Health Care USA, Inc.	4	2
Humana Medical Plan of Michigan Inc.	3	4
Meridian Choice Health Plan of MI, Inc.	3	4
Molina Healthcare of Michigan, Inc.	3	3
Stand-Alone Dental Plans		
BEST Life	83	6
Blue Cross Blue Shield of Michigan	83	4
Humana Insurance Company	83	1
Golden Dental Plans, Inc.	9	36
Dentegra Insurance Company	1	4

* Health plan totals include child-only QHPs. Insurers are not required to offer all of their plans in each county that they participate in.

Consistent with its role of providing plan management support for the health insurance marketplace, Michigan was actively engaged in the process of establishing an essential health benefits benchmark for the creation of qualified health plans. With most of its choices, Michigan (through the work of OFIR and later DIFS) opted for benefit standards that would mitigate

premium costs for consumers, while satisfying federal requirements. However, the EHB benchmark selection only applies for the 2014 and 2015 plan years, and it is not yet clear how benefits standards will be established in 2016 and thereafter.

Conclusion

The EHB requirement established by the ACA were intended to make coverage provided by individual and small group health plans more comparable to the coverage offered by large employers, thereby enhancing access and financial protection for consumers in those markets. The decision of HHS to use a state-by-state approach to define which services were considered essential made minimizing impacts on the market and premium costs a priority. However, the approach also required states to make significant decisions and created unique implementation features. By law, HHS is required to periodically review and update the EHB standard to account for any difficulties with access (coverage or affordability), market changes, and medical advances. HHS has stated that the minimum standards set by the EHB benchmarks will apply for at least 2014 and 2015 and that it will assess the benchmark process in 2016. The outcome of the assessment will likely inform future updates or modifications.

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[1] Most plans that existed prior to passage of the Affordable Care Act are considered to be "grandfathered" and do not need to meet all of the law's requirements, including the essential health benefits requirement. Health plans that have maintained the grandfathered status have been able to do so by not making any big changes in coverage, such as eliminating coverage of benefits for a particular condition and reducing the employer's share of the premium by more than 5 percent since March 23, 2010. See L. Levitt, *Grandfathering Explained* (Washington, D.C.: Kaiser Family Foundation, September 8, 2011). http://kff.org/health-reform/perspective/grandfathering-explained/ (accessed 7/1/14).

[2] Patient Protection and Affordable Care Act of 2010, Section 1302.

[3] J. Touschner. July 2012. *Child Health Advocates' Guide to Essential Health Benefits*. (Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families). http://ccf.georgetown.edu/wp-content/uploads/2012/08/EHB-Guide.pdf

[4] M. Buettgens, A. Nichols, S. Dorn. *Churning Under the ACA and State Policy Options for Mitigation* (Washington, D.C.: Urban Institute, June 2012). http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf (accessed 7/1/14).

[5] Center for Consumer Information and Insurance Oversight. December 16, 2011. *Essential Health Benefits Bulletin*. https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf (accessed 7/1/14).

[6] Institute of Medicine. *Essential Health Benefits: Balancing Coverage and Cost*. (Washington, D.C.: The National Academies Press, October 6, 2011). http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx (accessed 7/1/14).

[7] N. Bagley and H. Levy. December 10, 2013. Essential health Benefits and the Affordable Care Act: Law and Process. *Journal of Health Politics, Policy and Law* 39(2): 443–467.

[8] Center for Consumer Information and Insurance Oversight. December 16, 2011. *Essential Health Benefits Bulletin*.

[9] Kaiser Family Foundation. January 3, 2013. *State Health Facts. Essential Health Benefit Benchmark Plans, as of January 3, 2013*. http://kff.org/health-reform/state-indicator/ehb-benchmark-plans/ (accessed 7/1/14).

[10] Patient Protection and Affordable Care Act of 2010, Section 1311.

[11] C. White and A.E. Lechner. February 2012. *State Benefit Mandates and National Health Reform*. (Washington, D.C.: National Institute for Health Care Reform). http://nihcr.geekpak.com/State_Benefit_Mandates (accessed 5/10/14).

[12] Center for Consumer Information and Insurance Oversight. December 16, 2011. *Essential Health Benefits Bulletin*.

[13] L. Skopec, A. Henderson, S. Todd, P. Yong. *Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans* (Washington, D.C.: Office of the Assistance Secretary for Planning and Evaluation, December 2011). http://aspe.hhs.gov/health/reports/2011/marketcomparison/rb.pdf (accessed 7/1/14).

[14] K. Coleman. March, 7, 2013. Almost No Existing Health Plans Meet New ACA Essential Health Benefit Standards. *Health Pocket*. http://www.healthpocket.com/healthcare-research/infostat/few-existing-health-plans-meet-new-aca-essential-health-benefit-standards#.U6L6HPldVKK (accessed 7/1/14).

[15] Institute of Medicine. October 6, 2011. *Essential Health Benefits: Balancing Coverage and Cost*.

[16] Rehabilitative services are therapies intended to help a person relearn, maintain, or improve skills and functions, such as physical therapy to help someone relearn to walk after an accident. Habilitative services are intended to help a person learn new functions and skills, such as speech therapy for a child with a developmental disability.

[17]Center for Consumer Information and Insurance Oversight. December 16, 2011. Essential Health Benefits Bulletin.

[18] Institute of Medicine. October 6, 2011. *Essential Health Benefits: Balancing Coverage and Cost*.

[19] L. Skopec, A. Henderson, S. Todd, P. Yong. December 2011. *Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans*.

[20] The Department of Health and Human Services released its final rule for essential benefits on February 25, 2013. See *Federal Register* 78(37): 12834–12872. http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf (accessed 5/10/14).

[21] U.S. Department of Health and Human Services. December 16, 2011. ASPE Issue Brief: Essential Health Benefits, Individual Market Coverage. http://aspe.hhs.gov/health/reports/2011/individualmarket/ib.shtml (accessed 7/1/14).

[22] Alaska, Arkansas, and Maryland are the only states that selected benchmark plans that did not include mental health and substance use disorder services. All three states used another benchmark candidate, one of the largest Federal Employees Health Benefit Program (FEHBP) plans by enrollment, to supplement their selected benchmark plan.

[23] Passed in 1996, the Mental Health Parity Act (MHPA) prohibited large employer-sponsored group health plans from having more limits on mental health benefits compared to medical benefits. Congress expanded parity requirements in 2008 by passing the Mental Health Parity and Addiction Equality Act (MHPAEA). The MHPAEA prohibited those same health plans from applying policies regarding cost-sharing, out-of-network coverage, and treatment limits differently between medical and mental health benefits. In addition, MHPAEA also applied all parity requirements to substance use disorder services.

[24] The Department of Health and Human Services released its final rule for essential benefits on February 25, 2013. See *Federal Register* 78(37): 12834–12872. http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf (accessed 5/10/14).

[25] S. Goodell. April 3, 2014. Health Policy Briefs: Mental Health Parity. *Health Affairs*. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=112 (accessed 1/7/14).

[26] L. Skopec, A. Henderson, S. Todd, P. Yong. December 2011. *Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans*.

[27] American Academy of Pediatric Dentistry. N.d. *The State of Little Teeth*. http://www.aapd.org/assets/1/7/State_of_Little_Teeth_Final.pdf (accessed 7/2/14).

[28] S. Rosenbaum. *Access to Pediatric Oral Health Benefits offered through Health Insurance Exchanges*. (Washington, D.C.: Health Reform GPS, April 4, 2013). http://www.healthreformgps.org/resources/access-to-pediatric-oral-health-benefits-offered-through-health-insurance-exchanges/

[29] Children's Dental Health Project. May 9, 2013. *46 Organizations Urge Secretary of Treasury to Reconsider Premium Tax Credits for Pediatric Dental Benefits.* https://www.cdhp.org/resources/209-46-organizations-urge-secretary-of-treasury-to-reconsider-premium-tax-credits-for-pediatric-dental-benefits (accessed 7/2/14).

[30] A. Snyder, K. Kanchinadam, C. Hess, R. Dolan. *Improving Integration of Dental Health Benefits in Health Insurance Marketplaces*. (Washington, D.C.: National Academy of State Health Policy, April 2014). http://www.nashp.org/publication/improving-integration-dental-health-benefits-health-insurance-marketplaces (accessed 7/2/14).

[31] If the health plan has a single shared deductible, consumers could be required to meet the full deductible before pediatric dental services are covered.

[32]Kentucky, Nevada, and Washington have required consumers with children to purchase pediatric dental benefits on the marketplace.

[33] L. Skopec, A. Henderson, S. Todd, P. Yong. December 2011. *Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans*

[34] Kaiser Family Foundation. *State Health Facts, Essential Health Benefit (EHB) Benchmark Plans, as of January 3, 2013*.

[35] R. Snyder. September 28, 2012. Letter to the Honorable Kathleen Sebelius. http://www.michigan.gov/documents/lara/EHB_Gov_Benchmark_400142_7.pdf (accessed 7/2/14).

[36] State of Michigan. Executive Order No. 2013-1. January 16, 2013. http://www.michigan.gov/documents/snyder/EO_2013-1_408682_7.pdf (accessed 7/2/14).

[37] Premium effects were calculated by Wakely Consulting but were not adjusted for essential benefits missing from the candidates (e.g., habilitative services). Amounts displayed were relative to the leanest plans in terms of per member per month (PMPM) costs.

[38] Michigan Office of Financial and Insurance Regulation. September 25, 2012. *Michigan's Essential Health Benefits Benchmark Plan: Executive Report*, p. 16. http://www.michigan.gov/documents/lara/EHB_Report_09_05_12-Final_397063_7.pdf (accessed 7/2/14).

[39] Habilitative Services are defined as "health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities." State of Michigan Department of Licensing and Regulatory Affairs. January 7, 2013. *Order Requiring Coverage for Habilitative Services*. http://www.michigan.gov/documents/lara/1.7.13_Order_No_13-003-M_EHB_Habilitative_Services_407955_7.pdf (accessed 7/2/14).

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