



**Health Care Reform: The Question
of Essential Benefits**

The third report in Mercer's ongoing
series of topical surveys on health reform

Why a survey on essential benefits?

“Essential health benefits” make up part of the health care reform law’s mandates to broaden affordable access to adequate health coverage. For plan years starting on or after Sept. 23, 2010, group health plans – whether insured or self-insured, grandfathered or not – cannot impose lifetime dollar limits and they must gradually eliminate annual dollar limits on essential health benefits. Under reforms taking effect in later years, group health plans’ annual benefit summaries will have to delineate essential and other benefit offerings, and all qualified health plans sold through state-based insurance exchanges will have to cover essential health benefits.

Employers that have had to make plan changes to comply with the dollar-limit requirements have found that it is often not obvious whether a particular service or item is an essential health benefit, and opinions differ. The law only provides some general categories of services and directs regulators that any definitions of essential health benefits must reflect the scope of benefits offered in the “typical” employer plan. Regulators have said that they are working toward giving further guidance later in 2011.

Until further guidance is issued, regulators will take into account good faith efforts to comply with a “reasonable interpretation of the term ‘essential health benefits.’”

About the survey

To help employers make informed decisions and reasonable interpretations of the scope of benefits offered in a “typical” employer plan, Mercer surveyed employers about 26 specific health care services and items. We asked whether each service was covered under the plan in 2010 and whether any special benefit limitations applied. If an annual benefit dollar limitation was used, we asked about the amount. Finally, we asked whether employers with benefit limits in place had made changes for their 2011 plan year.

The findings in this report are based on our survey, conducted in March 2011, of 779 employers. Because health plan coverage can vary significantly based on employer size, we looked at the results for employers with fewer than 500 employees (157 respondents), 500–4,999 employees (401 respondents) and 5,000 or more employees (221 respondents).

Overview

Employer medical plans differ significantly in the types of coverage they include. Of the 26 services included in this survey, 10 are covered by at least 90% of respondents and seven are covered by 50% or less.

Prevalence of coverage

While the prevalence of these types of coverage varies somewhat by employer size, the difference in offer rates depends on the type of service covered. Some of the biggest differences were seen for bariatric surgery (covered by 70% of respondents with 5,000 or more employees, but only by 54% of those with fewer than 500 employees), acupuncture (covered by 52% and 34% of large and small employers, respectively), and temporomandibular joint (TMJ) treatment (covered by 62% and 48%, respectively). For the most common types of coverage, such as outpatient facilities, kidney dialysis or physical therapy, there was very little difference in the prevalence of coverage by employer size. It should be noted, however, that the smallest employer size category used in the survey was fewer than 500. If very small employers – those with fewer than 100 employees, for example – were examined separately, the gap in offer rates would very likely be wider.

Use of benefit limitations

Employers were asked about any special coverage limitations – beyond an overall annual or lifetime benefit maximum – that were in place for these 26 service categories in 2010. These limitations might be an annual dollar maximum for the service, a limit on the number of days or number of visits covered, or some other type of limit. Again, we found that the use of limitations varies widely by the type of service. For 15 of these services, less

than 50% of the respondents that included the coverage in their plans had special limitations; the services least likely to have coverage limits were outpatient facility services and kidney dialysis (for each, only 8% of respondents imposed special limits). The types of coverage for which respondents were most likely to place special limitations were orthodontia (82% of those providing this coverage), chiropractic care (72%), hearing aids (66%) and skilled nursing care (60%).

Changes made for 2011 in response to PPACA

Under the Patient Protection and Affordable Care Act (PPACA), employers were required to remove any lifetime benefit dollar maximums and to gradually eliminate any annual dollar limitations on essential health benefits. However, relatively few of the respondents with limits on the specific coverage categories examined in this survey made changes for 2011 – for the majority of the services, less than a fourth made changes. The most common change was simply to drop the use of a special coverage limitation, although some employers reported changing from a dollar maximum to a limit on the number of days or visits covered, which is permitted without restriction for essential health benefits. Employers were most likely to make changes to limitations on coverage for organ transplants (45%), outpatient facility charges (41%), durable medical equipment (34%), kidney dialysis (34%) and two forms of autism treatment (about 30% for each). Some of these changes may have been in response to the mental health parity law, which requires parity in the financial restrictions, such as dollar maximums, imposed on medical and mental health conditions.

What benefits are offered in a “typical” employer health plan?*

Covered by most employers				
	Percentage offering coverage	Percentage with some type of coverage limit in 2010	Among those with annual dollar limits in 2010, median amount	Of those with limits, percentage making change due to PPACA for 2011
Chiropractic services	94%	72%	\$1,000	23%
Skilled nursing care	93%	60%	\$10,000	13%
Physical therapy	99%	58%	\$2,900	20%
Occupational therapy	92%	57%	\$3,000	21%
Home health care	93%	56%	\$10,000	16%
Speech therapy (general)	85%	52%	\$3,000	25%
Durable medical equipment	97%	41%	\$5,000	34%
Hospice and palliative care	91%	41%	\$10,000	25%
Prosthetics	86%	34%	\$7,500	28%
Organ transplants	95%	22%	\$325,000	45%
Contraceptives	88%	12%	ID	10%
Outpatient facility charges	98%	8%	ID	41%
Kidney dialysis	95%	8%	ID	34%
Less often covered				
	Percentage offering coverage	Percentage with some type of coverage limit in 2010	Among those with annual dollar limits in 2010, median amount	Of those with limits, percentage making change due to PPACA for 2011
Orthodontia	49%	82%	\$1,500	1%
Hearing aids	43%	66%	\$1,500	19%
Infertility treatments	51%	58%	\$10,000	8%
Pediatric dental	46%	58%	\$1,500	9%
TMJ	55%	51%	\$1,500	22%
Acupuncture	41%	49%	\$1,000	15%
Speech, occupational and physical therapies for autism	61%	46%	\$5,000	30%
Nutritional counseling	53%	41%	ID	18%
Vision therapy	42%	39%	ID	8%
Pediatric vision	44%	38%	ID	15%
Prescribed drugs for nicotine addiction	64%	30%	\$500	29%
Applied behavioral analysis for autism	50%	29%	\$30,000	31%
Bariatric surgery	60%	26%	\$15,000	19%

*Sorted by percentage of employers with some type of coverage limit in 2010, in descending order; ID = Insufficient Data
Source: Mercer's 2011 Survey on Health Care Reform: The Question of Essential Benefits

Coverage prevalence and the use of special limitations

Chiropractic services

Chiropractic services are covered by 94% of respondents, with little variation in the prevalence of this coverage by employer size. The majority of those providing coverage (72%) placed a limit of some type on these benefits in 2010; when an annual dollar limit was imposed, the median dollar limit was \$1,000. None of the respondents with limits chose to drop coverage for chiropractic services in 2011; some dropped the use of limits (9%) or changed from a dollar limit to a day/visit limit (14%). The rest (77%) made no changes.

Skilled nursing care

Skilled nursing care is covered by most survey respondents (93%), regardless of their size. More than half of respondents (60%) placed some type of limit on the coverage in 2010, most often a day/visit limit. Among those reporting an annual dollar maximum, the median amount was \$10,000. While a few respondents with limits (8%) either dropped the use of limits or switched from a dollar limit to a day/visit limit (6%) for 2011, most (87%) made no changes.

Physical therapy

Physical therapy is covered almost universally (99%) by respondents of all sizes. More than half of respondents (58%) placed some type of limit on the coverage in 2010; among those reporting an annual dollar maximum, the median amount was \$2,900. While a few respondents with limits (10%) either dropped the use of limits or switched from a dollar limit to a day/visit limit (10%) for 2011, most (80%) made no changes.

Occupational therapy

Occupational therapy is covered by 92% of all survey respondents, ranging from 83% of those with fewer than 500 employees to 97% of those with 5,000 employees or more. More than half of respondents (57%) placed some type of limit on the coverage in 2010; among those reporting an annual dollar maximum, the median amount was \$3,000. While a few respondents with limits (10%) either dropped the use of limits or switched from a dollar limit to a day/visit limit (11%) for 2011, most (79%) made no changes.

Home health care

Most survey respondents (93%) cover home health care, with little variation by employer size. More than half of respondents (56%) placed some type of limit on the coverage in 2010, most often a day/visit limit. Among the few using an annual dollar maximum, the median amount was \$10,000. While a few respondents with limits (8%) either dropped the use of limits or switched from a dollar limit to a day/visit limit (7%) for 2011, most (84%) made no changes in response to PPACA.



Speech therapy

The majority of respondents (85%) cover general speech therapy. The prevalence of this coverage ranges from 73% of respondents with fewer than 500 employees to 87% of those with 5,000 or more. About half (52%) of those providing the coverage placed some type of limit on the coverage in 2010; among those reporting an annual dollar limit, the median amount was \$3,000. None of the respondents with limits chose to drop coverage in 2011; 10% dropped the use of limits and 15% changed from a dollar limit to a day/visit limit. The rest (75%) made no changes.

Durable medical equipment

Virtually all respondents (97%) cover durable medical equipment, with little variation by employer size. About two-fifths (41%) placed some type of limit on the coverage in 2010. Among those reporting an annual dollar maximum, the median amount was \$5,000. Nearly a third of the respondents with limits (32%) dropped the use of them and 2% switched from a dollar limit to a day/visit limit in 2011. The rest (66%) made no changes to limits in response to PPACA.

Hospice and palliative care

Hospice and palliative care are covered by 91% of survey respondents, with little variation by employer size. About two-fifths of respondents (41%) placed some type of limit on the coverage in 2010; among those reporting an annual dollar maximum, the median amount was \$10,000. About a fifth of the respondents with limits (21%) dropped the use of limits in 2011 and 4% switched from a dollar limit to a day/visit limit. The rest (75%) made no changes in response to PPACA.

Prosthetics

Most respondents (86%) provide coverage for prosthetics, regardless of employer size. Only about a third of respondents (34%) placed some type of limit on the coverage in 2010. Among those that reported an annual dollar maximum, the median amount was \$7,500. About a fourth of respondents with limits (26%) dropped the use of limits and 2% switched from a dollar limit to a day/visit limit for 2011. The rest (72%) made no changes.



Organ transplants

Nearly all employers (95%) cover organ transplants. There is little variation in the prevalence of this coverage by employer size. More than a fifth of these respondents (22%) placed special limitations on this coverage in 2010. Among employers with fewer than 500 employees, the median dollar limit was \$100,000; among those with 500 or more employees, it was \$500,000. Of all respondents with limits, more than two-fifths (42%) either removed the limit or changed from a dollar limit to a visit limit (3%) in 2011 in response to PPACA. The rest made no changes.

Contraceptives

Contraceptives are covered by 88% of respondents, with little variation in prevalence by employer size. Only 12% of those providing coverage placed any type of limit on the coverage in 2010. None of the respondents with limits chose to drop coverage in 2011. While 10% dropped the use of coverage limits in 2011, most (90%) made no changes.

Outpatient facility charges

Virtually all employers (98%) cover outpatient facility charges, with little variation in the prevalence of this coverage by employer size. Only 8% of these respondents placed any special limitations on this coverage in 2010. Of those, about two-fifths either removed the limit or changed from a dollar limit to a day/visit limit in 2011 in response to PPACA. The rest made no changes.

Kidney dialysis

Nearly all employers (95%) cover kidney dialysis. There is little variation in the prevalence of this coverage by employer size. Only 8% of respondents covering dialysis placed any special limitations on this coverage in 2010. Of those, about a third either removed the limit or changed from a dollar limit to a visit limit in 2011 in response to PPACA. The rest made no changes.

Orthodontia

Coverage for orthodontia is provided by nearly half of respondents (49%), ranging from 43% of those with fewer than 500 employees to 55% of those with 5,000 or more. The great majority of those providing coverage (82%) placed some type of limit on the coverage in 2010. Among those reporting an annual dollar maximum, the median amount was \$1,500. Virtually none of the respondents with limits made any changes in 2011 in response to PPACA.

Hearing aids

Just over two-fifths (43%) of respondents provide coverage for hearing aids, with little variation by employer size. The majority of those providing this coverage (66%) placed some type of limit on the coverage in 2010; among those reporting an annual dollar limitation, the median amount was \$1,500. A few of the respondents with limits (2%) dropped coverage for hearing aids in 2011, while 11% dropped the use of limits and 7% switched from a dollar limit to a day/visit limit. The rest (81%) made no changes to this coverage in response to PPACA.

Infertility treatment

Infertility treatment is covered by 51% of respondents, ranging from 46% of those with fewer than 500 employees to 57% of those with 5,000 or more. The majority (58%) of those providing coverage placed limits on the coverage in 2010. The median dollar limit was \$10,000. Only 8% of the employers with limits made any changes in response to PPACA: 1% dropped the coverage and 7% either dropped the limit or changed from a dollar limit to a day/visit limit. The rest made no changes.

Pediatric dental

Coverage for pediatric dental is provided by 46% of respondents, with little variation by employer size. More than half (58%) of those providing coverage placed some type of limit on the coverage in 2010. Among those reporting an annual dollar maximum, the median amount was \$1,500. While a few respondents with limits either dropped the use of limits (8%) or switched from a dollar limit to a day/visit limit (1%) for 2011, most (91%) made no changes in response to PPACA.

TMJ

Coverage for TMJ is provided by 55% of all respondents, ranging from 48% of employers with fewer than 500 employees to 62% of those with 5,000 or more. About half of those providing coverage (51%) placed some type of limit on the coverage in 2010. Among those reporting an annual dollar maximum, the median amount was \$1,500. About a fifth of respondents with limits (21%) dropped the use of limits and 1% switched from a dollar limit to a day/visit limit for 2011; the rest (78%) made no changes to limits in response to PPACA.

Acupuncture

Acupuncture is covered by 41% of all respondents, ranging from 34% of those with fewer than 500 employees to 52% of those with 5,000 or more. About half of those providing coverage (49%) placed a limit of some type on these benefits in 2010; when an annual dollar limit was imposed, the median dollar limit was \$1,000. None of the respondents with limits chose to drop coverage for acupuncture in 2011; some (5%) dropped the use of limits or changed from a dollar limit to a day/visit limit (10%). The rest (85%) made no changes.



Speech, occupational and physical therapies for autism

About three-fifths of respondents (61%) cover speech, occupational and physical therapies for autism. The prevalence of this coverage ranges from 54% of respondents with fewer than 500 employees to 63% of those with 5,000 or more. Close to half of those providing this coverage (46%) placed some type of limit on it in 2010; among those reporting an annual dollar limitation, the median amount was \$5,000. None of the respondents with limits chose to drop coverage in 2011; 16% dropped the use of limits and 14% changed from a dollar limit to a day/visit limit. The rest (70%) made no changes.

Nutritional counseling

Nutritional counseling is covered by 53% of respondents, ranging from 47% of those with fewer than 500 employees to 60% of those with 5,000 or more. About two-fifths of those providing coverage (41%) placed a limit of some type on these benefits in 2010. None of the respondents with limits chose to drop coverage for nutritional counseling in 2011; some (15%) dropped the use of limits or changed from a dollar limit to a day/visit limit (3%). The rest (82%) made no changes.

Vision therapy

Just over two-fifths of respondents (42%) cover vision therapy (a type of physical therapy for common visual problems such as lazy eye, crossed eyes, double vision, convergence insufficiency, and some reading and learning disabilities). Among respondents providing this coverage, 39% placed some type of limit on the coverage in 2010. While a few respondents with limits (6%) either dropped the use of limits or switched from a dollar limit to a day/visit limit (2%) for 2011, most made no changes (92%).

Pediatric vision

Coverage for pediatric vision is provided by 44% of respondents, with little variation by employer size. Nearly two-fifths of those providing coverage (38%) placed some type of limit on the coverage in 2010. While some respondents with limits (11%) either dropped the use of limits or switched from a dollar limit to a day/visit limit (4%) for 2011, most (85%) made no changes in response to PPACA.

Prescribed drugs for nicotine addiction

Prescribed drugs for nicotine addiction are covered by 64% of respondents. The prevalence of this coverage ranges from 53% of respondents with fewer than 500 employees to 69% of those with 5,000 or more. Less than a third of those providing coverage (30%) placed a limit of some type on this benefit in 2010. None of the respondents with limits chose to drop coverage in 2011. More than a fourth dropped the use of limits (28%) and 1% changed from a dollar limit to a day/visit limit. The rest (71%) made no changes.

Applied behavioral analysis for autism

Half of the respondents covered applied behavioral analysis for autism in 2010, with little variation by employer size. Less than a third of those providing the coverage (29%) placed a limit of some type on this coverage in 2010; among those with an annual dollar limit, the median amount was \$30,000. Just 2% of the respondents with limits chose to drop this coverage in 2011; 25% dropped the use of limits and 3% switched from a dollar limit to a day/visit limit. The majority of respondents with limits made no changes (69%).

Bariatric surgery

Bariatric surgery is covered by 60% of all respondents, ranging from 54% of those with fewer than 500 employees to 70% of those with 5,000 or more. About a fourth of those providing coverage (26%) placed a limit on these benefits in 2010; the median dollar limit was \$15,000. A handful of the employers with limits (4%) chose to drop coverage for bariatric surgery in 2011; more commonly, they made a change to the limit, either by dropping it (13%) or by changing from a dollar limit to a day/visit limit (1%). The rest made no changes.

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