Guidance on Essential Health Benefits

The Affordable Care Act (ACA) requires that any health insurance plan that is offered to an individual or small business must cover the ten broad categories of services that are listed below. This list applies to plans offered inside and outside of the Exchange and represents the **minimum services that must be covered**. Plans may cover additional services at their own discretion.

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
10. Pediatric services, including oral and vision care

The ACA required the US Department of Health and Human Services (HHS) to provide more details on the above categories in order to create a comprehensive essential health benefits (EHB) package. According to the ACA, the EHB package is intended to represent "the scope of benefits provided under a typical employer plan."

After receiving input from the Department of Labor (DOL), the Institute of Medicine (IOM), and other stakeholders, HHS released a "benchmark" approach for defining the EHB package. Below is a summary of the input that informed HHS's approach and the key takeaways from this process.

DOL Recommendations to HHS

The ACA directed DOL to "conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers" and report their results to HHS. In April 2011, DOL submitted to HHS a summary of Bureau of Labor Statistics National Compensation Survey results from 2008 and 2009. This summary included information on coverage and cost sharing by service category across employer plans.

IOM Recommendations to HHS

In September 2011, IOM submitted their recommendations to HHS on how the process of defining the EHB package should be conducted. Key aspects of their recommendations included the following.

- Start with a typical plan that is offered to *small* employers today.
- Modify it to include the ten EHB categories.
- Refine the package so that the cost meets an affordable "target premium."
- Create a process for updating EHB requirements based on evidence-based practices.
- Allow States the flexibility to create their own EHB packages as long as they meet the same standards as the federal package.

IOM cautioned that HHS and other Federal and State agencies must continue to develop strategies to reduce the growth of health care spending across all sectors to ensure that individual and small group plans will be able to meet affordability standards in future years.

Additional Input

HHS hosted a number of listening sessions to gain feedback from individuals, providers, State officials, and other parties regarding the content of the EHB package. Additionally, a number of states and organizations submitted letters to HHS advocating for the inclusion of specific benefits as EHB.

The "Benchmark" Approach

Rather than defining one EHB package that would apply to all states, HHS intends to propose that **each State may choose its own benchmark plan** to act as the EHB for that state. In a December 2011 Bulletin, HHS provided four benchmark options from which the State can choose.

- One of the three largest small group plans in the State by enrollment
- One of the three largest State employee health plans by enrollment
- One of the three largest federal employee health plan options by enrollment
- The largest HMO plan offered in the State's commercial market by enrollment

Effect on Current Health Plans

Once the State has chosen a benchmark plan, all other plans in the individual and small group markets will be required to offer benefits that are "substantially equal" to the benchmark. Plans will have the flexibility to adjust the specific services that are included as part of the benefit, as well as any quantitative limits on certain services, as long as the coverage has the same *value* as the benchmark.

Effect on State Mandates

The ACA requires States to pay for the portion of Exchange premiums that are attributable to state insurance mandates not included in the EHB package. This provision was intended to ensure that Federal dollars would not be used to subsidize coverage of state mandates in the Exchange.

However, by choosing a plan that is currently offered in the state, and therefore includes all current insurance mandates, the State essentially guarantees that no insurance mandates fall outside of the EHB package. HHS added that, while a state plan will likely remain a benchmark option through 2015, future updates to the benchmark may eliminate that possibility. Thus States are encouraged to continually monitor the necessity and effectiveness of their current state mandates.

Updating the Benchmark

HHS expects to formally propose that EHB benchmark options will be updated in the future to ensure that benefits reflect the most current and appropriate medical practices and insurance market practices. The schedule and scope of those updates has yet to be released, but will require carefully balancing the desire for innovation with the need for stability and reliability.