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Approach for Defining Essential Health Benefits

Beginning in 2014, the Affordable Care Act (ACA) requires non-grandfathered plans in the individual and small group markets to offer a comprehensive package of items and services, known as **essential health benefits** (EHBs). This requirement applies to plans offered inside and outside of the ACA's insurance Exchanges (Exchanges).

Self-insured group health plans, health insurance coverage offered in the large group market and grandfathered plans are not required to cover EHBs.

The ACA requires EHBs to reflect the scope of benefits covered by a typical employer and to cover at least 10 general categories of items and services. The ACA also directed the Department of Health and Human Services (HHS) to more specifically define the items and services that comprise EHBs.

On Dec. 16, 2011, HHS released an **informational bulletin** (Bulletin) outlining its proposed approach for defining EHBs. It was expected that HHS' guidance would detail the items and services that must be covered as EHBs. Instead, HHS' proposed approach deferred to the individual states by giving them flexibility to select their own benchmarks for defining EHBs. On Feb. 17, 2012, HHS also issued a series of **frequently asked questions** (FAQs) to supplement the Bulletin's guidance.

On Feb. 25, 2013, HHS released a **final rule** regarding the ACA's essential health benefits requirement. The final rule confirms HHS' prior guidance defining EHBs based on a state-specific benchmark plan.

ESSENTIAL HEALTH BENEFITS

The ACA provides that essential health benefits must include items and services within at least the following 10 categories:

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

As noted above, the ACA directed HHS to further define the scope of essential health benefits.

HHS APPROACH

Defining Essential Health Benefits

HHS has finalized its **benchmark approach** for defining essential health benefits. Under this approach, each state selects a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state.

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States can select their benchmark plan from the following options:

- 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; or
- The largest HMO plan offered in the state's commercial market by enrollment.

If a state does not select a benchmark plan, the default benchmark selected by HHS is the small group plan with the largest enrollment in the state.

The items and services included in the selected benchmark insurance plan comprise the essential health benefits package. However, if a state's benchmark plan does not cover the 10 categories of care specified under the ACA, the state or HHS will supplement the benchmark plan in that category.

More information on the benchmark plans, including the benchmark plan for each state, can be found on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

Making Benefit Design Decisions

The final rule requires health plans to offer benefits that are "substantially equal" to the applicable benchmark plan, modified if necessary to include the ACA's 10 categories of coverage. According to HHS, this provides health plans with flexibility to adjust benefits so long as they offer coverage for all 10 categories and the coverage has the same value.

In addition, the final rule clarifies that plans in the individual and small group markets must comply with the federal parity standards applicable to mental health and substance benefits in order to satisfy the requirement to cover essential health benefits.

The final rule also includes a number of standards to protect consumers against discrimination and ensure that benchmark plans offer a full array of essential health benefits and services. For example, the final rule:

- Prohibits benefit designs that could discriminate against potential or current enrollees;
- Includes special standards and options for health plans for benefits not typically covered by individual and small group policies today, including habilitative services; and
- Includes standards for prescription drug coverage to ensure that individuals have access to needed prescription medications.

Coverage of State Benefit Mandates

States typically have a number of benefit mandates, which require health insurance issuers to provide coverage for certain items or services. To prevent federal funding of state benefit mandates, the ACA requires states to defray the costs of state-mandated benefits in excess of essential health benefits for individuals enrolled in any plan offered through an Exchange.

However, as a transition for 2014 and 2015, if a state chooses a benchmark subject to state mandates (for example, one of the three largest small group plans in the state), the benchmark would include those mandates in the state's essential health benefits package. HHS' final rule provides that any state-mandated benefits enacted on or before Dec. 31, 2011 are included in the essential health benefits package for at least 2014 and 2015.

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