Essential Health Benefits: HHS Informational Bulletin
Fact Sheet

On December 16, 2011, the Department of Health and Human Services issued a bulletin outlining proposed policies that will give States more flexibility and freedom to implement the Affordable Care Act. This bulletin describes a comprehensive, affordable and flexible proposal and informs the public about the approach that HHS intends to pursue in rulemaking to define essential health benefits.

HHS is releasing this intended approach to give consumers, States, employers and issuers timely information as they work towards establishing Affordable Insurance Exchanges and making decisions for 2014. This approach was developed with significant input from the American people, as well as reports from the Department of Labor, the Institute of Medicine, and research conducted by HHS.

Essential Health Benefits

The Affordable Care Act ensures Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as "essential health benefits." Essential health benefits must include items and services within at least the following ten categories:

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, and
10. Pediatric services, including oral and vision care

Intended Approach: Comprehensive and Flexible

HHS intends to propose that essential health benefits are defined using a benchmark approach. Under the Department's intended approach announced today, States would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This approach would give States the flexibility to select a plan that would best meet the needs of their citizens.

States would choose one of the following benchmark health insurance plans:

- 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.

If States choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the State.

The benefits and services included in the benchmark health insurance plan selected by the State would be the essential health benefits package. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage.

To prevent Federal dollars going to State benefit mandates, the health reform law requires States to defray the cost of benefits required by State law in excess of essential health benefits for individuals enrolled in any plan offered through an Exchange. However, as a transition in 2014 and 2015, some of the benchmark options will include health plans in the State's small group market and State employee health benefit plans.

These benchmarks are generally regulated by the State and would be subject to State mandates applicable to the small group market. Thus, those mandates would be included in the State essential health benefits package if the State elected one of the three largest small group plans in that State as its benchmark.

This approach would provide maximum flexibility to States, employers and issuers while providing quality, comprehensive, coverage for consumers.

Coverage

Essential health benefits must include coverage of services and items in all 10 statutory categories. Based on our research, we believe that these benchmarks will cover most of the essential health benefits outlined by the Affordable Care Act. These categories include preventive care, emergency services, maternity care, hospital and physician services, and prescription drugs. If a State selects a benchmark plan that does not cover all ten categories of care, the State will have the option to examine other insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that must be included in the essential health benefits package.

Allowing Plans Flexibility to Innovate and Consumers Greater Choice

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are "substantially equal" to the benchmark plan selected by the State and modified as necessary to reflect the 10 coverage categories. Health plans also would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided they continue to offer coverage for all 10 statutory EHB categories and the coverage has the same value. Permitting flexibility will provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHBs offer a certain level of benefits.

Updating the Approach

The Department intends to propose that benchmarks will be updated in the future, and that State mandates outside the definition of essential health benefits may not be included in future years. The Bulletin also notes that updating the benchmark will allow benefits to reflect the most up-to-date medical and market practices.

How We Got Here: The Process

While the law calls on the Department to provide details regarding essential health benefits, this has been a team effort.

As required by the Affordable Care Act, in April, the Department of Labor provided a report to HHS on employer-sponsored health insurance coverage. This report detailed the benefits typically covered by employers. At the request of HHS, the Institute of Medicine provided its recommendations on a process for defining and updating the benefits that should be included in the essential health benefits package.

HHS also conducted a series of listening sessions to collect public comment and hear directly from the American people, doctors, nurses, Members of Congress and all interested stakeholders.

It is important to note that the Affordable Care Act distinguishes between a health plan's covered services, and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will be addressed in separate rules and will determine the actuarial value of the plan, expressed as a "metal level" as specified in statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.

Although this paper represents only the intended regulatory approach, public input on this paper is encouraged—comments can be sent on essential health benefits, are due by January 31, 2012, and can be sent to: EssentialHealthBenefits@cms.hhs.gov.

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