Essential health benefits (EHB) will be the minimum package of benefits that all new plans in the small group and individual health insurance markets will have to offer patients beginning in 2014 under the Affordable Care Act (ACA). The ACA only broadly defined the EHB as a package that must include 10 categories of services and left it to the Secretary of Health and Human Services (HHS) to develop a more detailed definition.\(^1\) However, HHS released a Bulletin on December 20, 2011 outlining a proposed approach to defining EHB that will allow each state to define their own EHB based on existing coverage options in the state.\(^2\)

A separate proposal outlines an approach to calculating the actuarial value of a plan. This is the measure of how much a typical patient can expect to pay out of pocket for all services and treatments they have in a year compared to how much will be covered by the plan. For example, a plan with an actuarial value of 60% will cover, on average, 60% of a patient’s health care costs over a year, with the patient responsible for 40% through deductibles and co-pays (although the co-pays for any given service may vary from that; the actuarial value is a measure of the total value of the plan). The ACA requires insurers to offer plans that fall into 4 tiers of coverage, from an actuarial value of 60% to 90%. The EHB, along with the actuarial value for a plan, will help patients understand the benefits that will be covered by their plan and the share of total costs they can expect to pay.

Below is a summary of the bulletin and the approach states can take to defining their EHB.

**The EHB will vary from state to state:** Under the Bulletin, states will define their EHB by choosing among “benchmark” plan options in their state. The benchmark plan selected by the state will serve as “reference plan, reflecting both the scope of services and any limits offered by a ‘typical employer plan’ in that state.” In other words, the EHB can include any non-monetary limits (e.g., visit limits, days in the

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\(^{1}\) The 10 categories listed in the ACA are: Ambulatory patient services (i.e., doctor visits); emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management services; and pediatric services, including oral and vision care.

States can choose from four benchmark plan types for 2014 and 2015:

- The largest plan by enrollment in any of the 3 largest small group insurance products in the state;
- Any of the 3 largest state employee plans by enrollment;
- Any of the 3 largest national Federal Employee Health Benefit (FEHB) plan options by enrollment; or
- The largest insured commercial non-Medicaid HMO in the state.

If a state doesn’t choose a benchmark, the default benchmark plan will be the largest plan by enrollment in the largest product in the state’s small group market. Enrollment is based on enrollment data from the 1st quarter of 2012 and states must choose an EHB by the 3rd quarter of 2012. The state-selected EHB will apply for 2014 and 2015.

**States can avoid extra costs for state-required coverage:** Under the ACA, if a state wants to require the EHB to include coverage for services and treatments required under state “mandate” laws, the state would have to defray the cost associated with those benefits for everyone enrolled in an exchange plan (whether they qualify for a subsidy or not). Under the Bulletin, states will have a transition period for 2014 and 2015 in which they will not be responsible for defraying the cost of state mandates if the benchmark chosen is one that is required to comply with state mandate laws. If the benchmark chosen is not subject to state mandates (ie, FEHBP and, in some cases, the state employee plan or largest HMO), the state is responsible for the cost of any mandates required beyond the benchmark plan.

**The benchmark plan must include coverage of all 10 benefit categories:** If a category from the ACA’s list of 10 is missing from the chosen benchmark plan, states will have to add the category to the state EHB. The most commonly non-covered services among typical employer plans are habilitative services and pediatric oral and vision services.

**Insurers may have some flexibility in benefit design:** The Bulletin borrows from the approach states may now use for setting benefit requirements for plans offered under the Children’s Health Insurance Program (CHIP). As under CHIP, plans will be required to offer benefits that are “substantially equal” to the benefits of the benchmark plan, “and modified as necessary to reflect the 10 coverage services.”

However, the Bulletin proposes to allow insurers flexibility in meeting that test for similar benefits. For example, under the Bulletin, insurers will have flexibility to adjust benefits, “including both the specific services covered and any quantitative limits” as long as they cover all 10 statutory categories. In particular, HHS is considering giving insurers flexibility to make substitutions only within each of the 10 benefit categories or to allow substitutions across the 10 benefit categories, as long as the substitutions result in a package that is equal to the benchmark in actuarial value.

In addition, the Bulletin would allow insurers to vary the specific drugs on a plan’s formulary, so long as the plan offers at least one drug in the category and class of drugs covered in the benchmark. However,
in response to criticism of this, HHS is considering requiring insurers to offer more than one drug in each class of drugs, as is typically done in plans sold to small employers, individuals and others.

**Two year transition:** This state-based approach to defining EHBs would be in effect for 2014 and 2015. In 2016, HHS would evaluate the process for defining the EHB, as well as whether there are any state mandates that should be excluded from the state EHB package.