The Essential Health Benefits Package

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The essential health benefits package ("EHB") is a benchmark set of benefits chosen by the state that will be hugely influential on the entire health care marketplace. The federal Patient Protection and Affordable Care Act ("ACA") requires that, beginning in 2014, most health plans in the individual and small group markets must cover the state's EHB, and most plans may not impose annual or lifetime benefit caps on benefits included in the EHB[1]. Furthermore, the levels of coverage offered within the Exchange will be categorized by their value as a percentage of the value of the state's EHB.

The EHB Must Include 10 Benefit Categories

The ACA gives the Secretary of the federal Department of Health and Human Services ("Secretary," "HHS") broad discretion in defining the EHB. It does, however, list ten benefit categories which must be covered in the EHB, consisting of the following:

TEN REQUIRED BENEFIT 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
10. Pediatric services, including oral and vision care

The ACA also requires states in 2016 to begin defraying the cost of any benefits required by state law which exceed the scope of the EHB. This requirement may impact California's choice of EHB due to the state's more than 50 benefit mandates.

The Institute of Medicine's Report

At the request of the Secretary, the Institute of Medicine ("IOM") undertook a study to make recommendations on the criteria and methods for determining and updating the EHB, but not specify details of the EHB itself. After more than a year of stakeholder workshops and research, the report, Essential Health Benefits: Balancing Coverage and Cost, was released October 7, 2011.

The report recommended that HHS determine an affordable premium then use that premium target to guide what benefits should be included in the EHB. The report further suggested that a state be permitted to largely define its EHB, within certain parameters, and that HHS annually update the EHB, beginning in 2016, based on evidence of effectiveness with the goal of increasing the specificity of benefit requirements and promoting value for consumers.

HHS Allows the State to Choose Its Benchmark Plan

On December 16, 2011, HHS released its first "Essential Health Benefits Bulletin," which departed from the IOM recommendations. Instead of setting a national floor on benefits, as suggested in the IOM report, the bulletin outlines a benchmarking approach. HHS effectively shifted many of the more difficult coverage and affordability questions on the EHB to the states and indicated that many key issues, such as cost-sharing, actuarial value calculation, and EHB implementation in the Medicaid program, will be addressed in future bulletins.

The benchmark approach requires states to select one of four benchmark plan options that reflect the scope of

services offered by a "typical employer plan." The benefits and services included in the benchmark plan selected by the state would be the EHB and would be used as the basis for determining the value of all plans offered through the Exchange. For instance, a bronze level plan offered through the Exchange would provide coverage at a value equivalent to 60 percent of the full actuarial value of the benchmark plan. The four benchmark plan options are described below:

Benchmark Plan Option	Choice(s) in California under the Benchmark Option		
One of the three largest state employee plans by enrollment	Kaiser HMO	Blue Shield Basic HMO	Anthem Blue Cross PERS Choice PPO
One of the three largest federal employee health plans by enrollment	Blue Cross Blue Shield Basic	Blue Cross Blue Shield Standard	Government Employees Health Association (GEHA)
Largest HMO plan offered in the state's commercial market by enrollment	Large Group Kaiser Traditional HMO		
One of the three largest small group plans in the state by enrollment*	Small Group Anthem Blue Cross (Solution 2500) PPO	Small Group Kaiser HMO	Small Group Blue Shield (Spectrum PPO Plan 1500 Value)

*The small group plans will not likely be confirmed until after March 31, 2012.

Health plans would be required to offer benefits that are "substantially equal" to the benchmark plan selected by the state and modified as necessary to reflect the 10 coverage categories, but plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. HHS is also considering allowing benefit substitution across benefit categories.

If a state chooses not to select a benchmark, HHS intends to propose that the default benchmark be the small group plan with the largest enrollment in the state.

Moving Forward

California's Exchange Board is currently assessing the state's choice of benchmark plan option with input from stakeholders, though many important questions remain unanswered. HHS has indicated that States must choose a benchmark plan no later than Fall 2012.

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1. Plans that were in existence as of March 23, 2010 may be exempt from EHB requirements. Significant changes in the plan post-ACA implementation, however, will cause it to lose its grandfathered status.