# Essential Health Benefits

The Patient Protection and Affordable Care Act (PPACA) makes a range of reforms to the private health insurance market in the United States. It provides for the creation of health benefit exchanges in each state and adds consumer protections to health plans offered both inside and outside of the exchanges. One important protection is the establishment of a package of essential health benefits that will help assure certain plans — including all exchange plans — provide adequate benefits to their enrollees.

The details of the essential health benefits package will be determined by the Secretary of Health and Human Services in a future regulation.[1] The law, however, establishes a set of mandated benefit categories and describes which plans will be required to offer the essential health benefits.

## Benefits and Cost Sharing

PPACA defines standards for both the types of benefits to be covered and the cost-sharing to be applied under the essential health benefits package. In addition, it sets actuarial value standards for plans, based on what is covered under the essential benefits package. In other words, plans will be required to cover the full scope of benefits defined in the essential benefits package, but the level of cost-sharing an individual will face for a covered item or service will depend on the actuarial value of the policy he or she purchases. In general, the essential health benefits are intended to mirror the typical employer-sponsored plan.[2]

The Secretary is directed to define a package that includes, at a minimum:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care[3]

[1] PPACA § 1302(b).
[2] § 1302(b)(2).
[3] § 1302(b)(1).

While it requires coverage for each of these categories of benefits, the law does not name the specific services that must be covered or the amount, duration, and scope of covered services. The Secretary will define the specific benefits within each of the categories and will update the package to address gaps or to respond to changing medical practices. For instance, within the preventive services category, the Secretary will include smoking cessation, mammography, and certain colorectal screenings as covered benefits because they have received an "A" or "B" recommendation from the U.S. Preventive Services Task Force.

In defining the benefits package, the Secretary must decide not only which health services will be included, but also how much discretion to leave to health plans in coverage decisions. For example, will the Secretary determine how many counseling sessions are covered for smoking cessation, or whether medications are included, and which ones? Or will a plan be permitted to decide the number of covered sessions and medications? The Secretary will need to make critical decisions about the level of discretion to leave to health plans.

While the law enumerates certain considerations that must be taken into account, the Secretary retains wide authority in making determinations on covered services. And while the law requires an opportunity for public comment, it does not define a procedure for involving stakeholders like cancer patients, clinicians, or experts in cancer care. Advocates, therefore, will need to seek out opportunities to weigh in to make sure important benefits are included.

Currently, many of the requirements that health plans cover certain services are imposed by state law. The National Conference of State Legislatures identified 25 cancer-related benefit requirements enacted in at least one state.[4] PPACA allows states to continue to mandate certain benefits. If the mandated benefits are not included in the essential health benefits, however, states will be required to pay for any increased premium costs in the exchanges stemming from the state mandates. A state must reimburse exchange plans or the individuals who purchase the plan for any cost associated with offering the additional benefits.[5] Since this is likely to discourage states from mandating benefits, it's critical that the full range of items and services needed to prevent and treat cancer are included in the essential health benefits package.

The law links the essential health benefits package to certain cost-sharing limits — plans that are required to offer the essential health benefits package will also be required to limit the cost-sharing they charge. Specifically, plans providing the package will be prohibited from imposing an annual cost-sharing limit that exceeds the limits that apply to high deductible plans linked to health savings accounts. Currently, those limits are $5,950 per year for individuals and $11,900 per year for families.[6] Further, small group plans must limit deductibles to $2,000 for individual coverage and $4,000 for family coverage. As with other health plans under the reform law, deductibles must

[4] Karmen Hanson and Erik Bondurant, "Cancer Insurance Mandates and Exceptions," National Conference of State Legislatures, August 2009, http://www.ncsl.org/portals/1/documents/health/CancerMandatesExcept09.pdf.
[5] § 1311(d)(3).
[6] These amounts will be indexed to the rate of average premium growth. Kaiser Family Foundation, Summary of New Health Reform Law, April 2010, http://www.kff.org/healthreform/upload/8061.pdf.
[7] § 1302(c).

not apply to evidence-based preventive health services, including those that have an A or B rating in the current recommendations of the United States Preventive Services Task Force.[7]

By varying cost-sharing amounts within the allowable limits, each plan offered inside or outside of the exchanges (see below for exceptions) will be required to provide a level of coverage that represents a specific fraction of the actuarial value of the full essential health benefits package. Plans will cover 60% (Bronze), 70% (Silver), 80% (Gold), or 90% (Platinum) of the full actuarial value of the essential health benefits for a standard population.[8]

## Which Plans Must Offer the Essential Health Benefits Package?

PPACA aims to provide benefit protections both inside the exchanges it creates and outside of them. To be offered in the exchanges, health plans must be "qualified." One criterion for qualification is to offer the essential health benefits package with the associated cost-sharing limits.[9]

Exchange plans, though, will initially only be available to small employers and to individuals who do not have an affordable offer of employer coverage and are not eligible for Medicare or Medicaid. Larger employers and others not eligible for exchange plans will continue to purchase coverage outside of the exchanges. For plan years that begin after January 1, 2014, PPACA requires that individual and small group plans offered outside the exchanges include the essential health benefits package. The law further requires that all new group health plans after the same date limit the cost-sharing and deductibles to the limits specified for the essential health benefits package (though large group plans are not required to cover the benefits themselves).[10]

| For Plan Years Beginning January 1, 2014 or Later | | | Must Provide Essential Health Benefits | Must Limit Cost Sharing and Deductibles |
|---|---|---|---|---|
| Exchange Plans | Small Group | | Yes | Yes |
| | Non-Group | | Yes | Yes |
| Non-Exchange Plans | New Plans | Self-insured | No | No |
| | | Large Group | No | Yes |
| | | Small Group | Yes | Yes |
| | | Non-Group | Yes | Yes |
| | | Basic Health | Yes | Yes |
| | Grandfathered Plans | Self-insured | No | No |
| | | Large Group | No | No |
| | | Small Group | No | No |
| | | Non-Group | No | No |

[8] § 1302(d).
[9] § 1301(a)(1)(B).
[10] § 1201

PPACA authorizes states to offer a basic health plan in lieu of exchange coverage to certain moderate-income individuals. These basic health plans, too, must cover the essential health benefits.

## Conclusion

Under reform, many health plans will be required to offer the essential health benefits package. This requirement will help ensure that enrollees have access to a full range of services, but the details of what it will include are yet to be decided. Advocates for cancer patients have an important role to play as the Secretary of Health and Human Services works to define the specifics of the package — it will form the core set of benefits in the small group and non-group markets both inside and outside of the health benefit exchanges. Because the reform law discourages states from mandating additional benefits within the exchanges, it is all the more important to include vital benefits in the package.

*by Joe Touschner and Sabrina Corlette*