

Additional Information on Essential Health Benefits Benchmark Plans

Background

Beginning in 2014, the Affordable Care Act requires non-grandfathered health plans to cover essential health benefits (EHB), which include items and services in the following ten 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; and (10) pediatric services, including oral and vision care. The essential health benefits should be equal in scope to a typical employer health plan.

In the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule ("EHB Rule"), HHS defines EHB based on state-specific EHB-benchmark plans. This page contains information on EHB-benchmark plans for each of the 50 states, the District of Columbia (D.C.), and the U.S. territories. Two documents are provided for each EHB-benchmark plan in the 50 states, D.C. and Puerto Rico: (1) a summary of the plan's specific benefits and limits, and list of covered prescription drug categories and classes; and (2) state-required benefits.

The summaries of the covered benefits and limits, and lists of prescription drug categories and classes have been compiled based on the EHB-benchmark plan selection process described in 45 CFR 156.100 and 156.110. These summaries describe the EHB-benchmark plans that have been selected by states, as well as those that have been developed by HHS using the default benchmark plan selection process described in 45 CFR 156.100(c) and the supplementation methodology in 45 CFR 156.110.

Because EHB-benchmark plan benefits are based on 2012 plan designs, and include state-required benefits that were enacted before December 31, 2011, some of the benchmark plan summaries may not reflect requirements effective for plan years starting on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan, beginning in 2014, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations.

A list of each state's required benefits has also been compiled to help states and issuers determine the state-required benefits in excess of EHB. We consider state-required benefits (or mandates) to include only specific care, treatment, or services that a health plan must cover. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements, and state requirements relating to service delivery method (e.g., telemedicine) to be state-required benefits.