Definition of Essential Health Benefits Left to States

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The Department of Health and Human Services (HHS) outlined its proposal for defining ?ÃÂ£essential health benefits?ÃÂ¥ which must be provided by group health plans beginning in 2014. The Patient Protection and Affordable Care Act directs the Secretary of HHS to define essential health benefits, but provides that it must at least include 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, and pediatric services (including oral and vision care). Under the HHS proposal, essential health benefits will be defined by a benchmark plan selected by each state. States may choose one of four benchmark 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, or the largest insured commercial HMO operating in the state. For states that do not select a benchmark, a default benchmark will apply - the small group plan with the largest enrollment in the state. This proposal is available here.

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