



Essential Benefits Package

What is the essential benefits package?

The Affordable Care Act (ACA) makes a range of reforms to the private health insurance market in the United States. It provides for the creation of 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 benefits package will be determined by the Secretary of Health and Human Services (HHS) in a future regulation. The law, however, establishes a set of mandated benefit categories and describes which plans will be required to offer the essential benefits package.

What benefits will be included in the essential benefits package?

The ACA defines standards for both the types of benefits to be covered and the cost sharing to be applied under the essential 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 benefits package is intended to mirror the typical employer-sponsored plan. The Secretary of HHS 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

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.

Currently, many of the requirements that health plans cover certain services are imposed by state law under state “mandate” laws. ACA allows states to continue to mandate certain benefits. However, if the mandated benefits are not included in the essential benefits package, states will be required to pay for any increased premium costs for qualified health plans stemming from the state mandates. A state must reimburse qualified health plans or the individuals who purchase the plan for any cost associated with offering the additional benefits.

What are the cost sharing requirements for the essential benefits package?

The ACA links the essential benefits package to certain cost sharing limits—plans that are required to offer the essential 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 \$6,050 per year for individuals and \$12,100 per year for families.¹ 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 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.

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 standardized level of coverage that represents a share of the actuarial value of the full essential benefits package. Plans will cover 60% (Bronze), 70% (Silver), 80% (Gold), or 90% (Platinum) of the full actuarial value of the essential benefits package for a standard population.

Which plans must offer the essential benefits package?

The ACA aims to provide benefit protections for coverage offered 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 benefits package with the associated cost sharing limits.

¹ These amounts will be indexed annually to the rate of average premium growth. .

Exchange plans, though, will initially only be available to small employers and to individuals who do not have an affordable or adequate 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, ACA requires that individual and small group plans offered outside the exchanges include the essential 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 benefits package (though large group plans are not required to cover the benefits themselves).

ACA 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 benefits package.

For Plan Years Beginning January 1, 2014 or Later		Must Provide Essential Benefits Package	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 ²	Self-insured	No	No
		Large Group	No	No
		Small Group	No	No
Non-Group		No	No	

² Grandfathered plans, under the ACA, are plans that were offered on March 23, 2010 and have made few changes to their benefits and co-pays. As changes are made, including higher co-pays and the elimination of covered services, plans will lose this status and have to comply with requirements that apply only to “new” (i.e., non-grandfathered) plans.