



Designing the Essential Health Benefits for Your State

An Advocate's Guide

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The Affordable Care Act established a minimum floor of services that all health plans in the individual and small group market will be required to cover starting in 2014, called the essential health benefits (EHB). This important provision of the health care law is meant to ensure that all individuals and families are guaranteed coverage for certain essential health services, regardless of which health plan they choose.

The Affordable Care Act included 10 broad categories of services that the essential health benefits package must cover. However, the law left it up to the Secretary of the Department of Health and Human Services (HHS) to define exactly what items and services will be covered within these broad categories and at what scope. Earlier this year, HHS released guidance describing its intended approach for defining the scope of health services included in the essential health benefits for the first couple of years. Rather than create one federal definition, HHS gave each state the authority to define exactly what items and services will be included in its essential health benefits package in 2014 and 2015. This package must be based on a benchmark plan selected by the state. The benchmark plan will play a significant role in determining which services will be included in that package.

As states move forward selecting their benchmark plan and defining their essential health benefits package, it's critical that consumer advocates are involved in the process. This guide includes an overview of the requirements a state's essential health benefits package will have to meet under the Affordable Care Act and outlines the process for defining these benefits using a benchmark plan. It then provides guidance on how to analyze your state's benchmark plan options and highlights potential avenues for advocacy.

The Affordable Care Act and the Essential Health Benefits

Under the health care law, the essential health benefits package will affect coverage offered in most types of health plans. Starting in 2014, all non-grandfathered health plans sold in the individual and small group markets, both inside and outside an exchange, must cover at least the essential health benefits package.¹ Individuals newly eligible for Medicaid under the health care law and individuals enrolled in a state Basic Health Program will also be guaranteed coverage for the 10 categories of essential health benefits.²

Not all health plans will be required to cover the essential health benefits. However, even health plans not required to cover all services included in the essential health benefits will still be affected by this package. This is because the law prohibits all health plans from placing any annual or lifetime dollar limits on their coverage of services included in the essential health benefits, regardless of whether they are required to cover the entire essential health benefits package. This provision of the law will affect self-insured group health plans, large group market health plans, and grandfathered health plans.³

The Affordable Care Act gave the Secretary of HHS the authority to define what specific services would make up the essential health benefits. However, the law did set certain requirements that the Secretary's definition must meet (see Section 1302 of the Affordable Care Act). The Secretary's definition of the essential health benefits must include coverage for at least the following 10 broad categories of services:

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
10. Pediatric services, including oral and vision care

The essential health benefits package must provide balanced coverage across these 10 categories. The law also requires that the scope of services covered in the essential health benefits package be equivalent to the scope of services covered in a "typical employer plan," as determined by the Secretary.⁴

In addition to these guidelines, the Affordable Care Act established critical nondiscrimination and parity requirements that the essential health benefits definition must meet. Under the law, the essential health benefits must “take into account the health needs of diverse segments of the population, including women, children, persons with disabilities and other groups.”⁵ Further, the law explicitly prohibits the essential health benefits from being designed in “ways that discriminate against individuals because of their age, disability, or expected life,” and it prohibits the denial of essential health benefits services based on age, life expectancy, disability, degree of medical dependency, or quality of life.⁶

Mental health and substance use disorder services are required to be part of the essential health benefits package. The Affordable Care Act also requires that all qualified health plans (QHPs) sold in an exchange and all plans sold outside the exchange in the individual market comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).^{7,8} This means that all qualified health plans and plans sold in the individual market must cover mental health and substance use disorder services as part of the essential health benefits, and they must cover these services at parity with their medical and surgical benefits, to comply with MHPAEA. All of these requirements are meant to limit health plans from creating benefit packages that discriminate against the health needs of certain populations.

HHS Guidance for Defining a State’s Essential Health Benefits

This past January and February, HHS released guidance and frequently asked questions on essential health benefits.

These bulletins outline a proposed interim approach to defining the essential health benefits for at least 2014 and 2015. Rather than create one federal definition of what specific services are included in the essential health benefits package, HHS has proposed giving each state the authority to select a benchmark plan that will be used to define the scope of services covered in a state’s essential health benefits package. This benchmark plan will be selected from one of 10 existing insurance plans in a state, which are discussed in more detail on the following pages. Since the plans that HHS has chosen to serve as potential benchmarks are offered by employers and serve many people, the benchmarks can be thought of as “typical employer plans” until the Secretary of HHS makes a different determination of what is typical.⁹ The benefits of a state’s benchmark plan will largely define the scope of services the essential health benefits will cover for each of the 10 broad categories of services it is required to cover under the Affordable Care Act. It may be supplemented with additional benefits, as necessary, to meet all the requirements for the essential health benefits set forth in the health care law. HHS plans to revisit this benchmark approach in 2016.



HHS Guidance

Essential Health Benefits

Bulletin, available online at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

Frequently Asked Questions (FAQ) on Essential Health Benefits Bulletin, available online at <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.

HHS's most recent FAQ clarified that, under this proposed approach, a state will have to select two distinct essential health benefits benchmark plans: one to define the essential health benefits package for private market plans and another to define the essential health benefits package that will apply to Medicaid. While there is some overlap, the essential health benefits benchmark plan options for the private market and for Medicaid are not identical. In addition, in order to best serve the health needs of the Medicaid population, which is lower income and has greater medical needs, it may be better for a state to adopt a different benchmark plan for Medicaid than for its private market. This guide addresses only the proposed process for determining the essential health benefits package that will apply to private plans in the individual and small group market.

The Essential Health Benefits Benchmark Plan

■ Selecting a Plan

In defining their essential health benefits package for private market plans, states will have to select the benefit package of one of the following 10 benchmark plan options as their essential health benefits benchmark plan:

- The largest plan (by enrollment) in each of the state's three largest small group insurance products,
- Any of the three largest (by enrollment) state employee plans,
- Any of the three largest (by enrollment) national Federal Employees Health Benefits Program (FEHBP) plans, or
- The largest (by enrollment) non-Medicaid HMO in a state.

A state's benchmark plan options are determined based on enrollment data from the first quarter of 2012. HHS has identified the Federal Employees Health Benefits Program benchmark plan options and the small group product benchmark options for each state. States are responsible for identifying the state employee plans and HMO plan that are potential benchmark plans for their state. States will have to actively select an essential health benefits benchmark plan by the third quarter of this year, or September 2012. If a state does not select a benchmark plan, the default benchmark plan (the largest plan by enrollment in the largest small group insurance product in the state) will become the state's benchmark plan.

■ Defining the Services Included in the Essential Health Benefits Package

A state's benchmark plan will act as a starting point for defining what services are covered in the essential health benefits package. The scope and amount of benefits in its benchmark plan will largely define the scope and amount of benefits covered under each of the 10 categories of services. For example, whatever maternity services a state's benchmark plan covers will largely define what maternity services a state's

essential health benefits will cover. Also, for the most part, a state's essential health benefits package will incorporate the limits on services included in the benchmark plan, including any limits on the amount of services, such as day or visit limits, and qualitative limits on services, such as prior authorization requirements or step therapy requirements for prescription drugs.

However, the final essential health benefits package, including any benefit limits incorporated into the package, will still have to meet all nondiscrimination requirements under the health care law. This means that if a state's benchmark plan includes restrictive benefit limits that violate the nondiscrimination requirements for the essential health benefits, they should not be incorporated into a state's essential health benefits package.

HHS's proposed approach for defining the prescription drug coverage included in a state's essential health benefits package varies slightly from how coverage for other categories of services will be defined. A state's essential health benefits package will not adopt the exact same drug coverage as its benchmark plan. Instead, insurance plans will only have to cover at least one drug in each category and class of drugs covered in a state's benchmark plan in order to provide the essential health benefits. Under this approach, insurers will have the flexibility to decide which drug(s) they cover within each required category and class. It is possible that this could change in future federal guidance.

The essential health benefits will not incorporate any cost-sharing, such as copays, or any dollar limits included in a benchmark plan. However, HHS has proposed allowing insurers to substitute any dollar limits included in a benchmark plan with actuarially equivalent non-dollar limits, such as day or visit limits. As such, it is important that dollar limits be taken into consideration when a state is deciding which benchmark plan to select.

■ **Supplementing a Benchmark Plan to Meet the Essential Health Benefits Requirements**

If a state's benchmark plan does not cover one or more of the 10 categories of services that the essential health benefits is required to cover under the Affordable Care Act (see list on page 2), a state will have to supplement its essential health benefits package with additional benefits from one of the other benchmark plan options. For example, if a state selects a benchmark plan that does not offer rehabilitative coverage, that state will have to supplement its essential health benefits package with the rehabilitative benefits from another benchmark plan.

HHS provided additional guidance on how states will supplement a benchmark plan with coverage for habilitative services and pediatric dental and vision services, as these types of services are not traditionally offered in health plans today. HHS

is currently considering two potential options for supplementing coverage for habilitative services. The first would require plans offering the essential health benefits to cover the same services for habilitative care as they cover for rehabilitative care, and to cover them at parity. The second would allow individual plans to decide which habilitative services to cover and report this coverage directly to HHS.

In order to provide pediatric dental services, HHS is considering allowing states to supplement their benchmark plan with the dental benefits from either the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the highest enrollment, or a state's Children's Health Insurance Program (CHIP). To provide pediatric vision services, HHS is considering allowing states to supplement their benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment. Additional guidance from HHS is necessary to fully understand how states will supplement a benchmark plan with coverage for habilitative services and pediatric dental and vision services.

■ **Addressing State-Mandated Benefits**

The Affordable Care Act requires a state to cover any cost resulting from state-mandated benefits that are not included in the essential health benefits package and that qualified health plans (QHPs) offered in an exchange are required to cover. If a state adopts a benchmark plan that includes state-mandated benefits, those benefits can be incorporated into a state's essential health benefits package. A state can only incorporate state-mandated benefits within a benchmark plan that were enacted by December 31, 2011. This is a transitional policy for 2014 and 2015. HHS plans to reevaluate this approach in 2016 and may decide to exclude some state mandates from the essential health benefits package then.

■ **Giving Plans Benefit Design Flexibility**

HHS has proposed giving insurance plans the flexibility to vary the services they cover or the limits they place on benefits within each of the 10 benefits categories defined by the state's essential health benefits package. If a plan chooses to vary a benefit for one of the 10 categories offered in the essential health benefits package, the benefit substitution must be actuarially equivalent to the coverage offered by the benchmark plan. For example, a state's essential health benefits package may offer coverage for rehabilitative services that covers 30 physical therapy visits and 30 occupational therapy visits. An insurance plan could choose to cover more physical therapy visits and decrease the number of occupational therapy visits it covers. As long as this substitution is actuarially equivalent and not discriminatory, this plan would still meet its requirement to cover the essential health benefits even though its coverage varies from the state's essential health benefits package.

Advocating for a Robust Essential Health Benefits Package in Your State

While there are still some remaining questions regarding how states are permitted to define the essential health benefits, many states are beginning to move forward in selecting their benchmark plan. A state's benchmark plan will play a significant role in defining the scope and amount of benefits offered in each of the 10 categories of services covered in a state's essential health benefits package. In order to advocate for the most comprehensive benchmark plan, advocates need to know what their state's benchmark plan options are and identify which one has the most comprehensive benefits to meet the health needs of diverse populations. The following sections offer steps advocates can take to engage in the process of defining the essential health benefits package in their state. (See "Defining Your State's Essential Health Benefits" on page 9 for a quick summary of this process and guidance on possible advocacy efforts for each step.)

■ Identifying Benchmark Plans and Obtaining Plan Documents

The first step is to identify your state's 10 potential benchmark plans. HHS recently released a list of the three largest small group products in each state, the three Federal Employees Health Benefits Program (FEHBP) plans that are potential benchmark plans, and the largest Federal Employees Dental and Vision Insurance Program (FEDVIP) plans, as of March 31, 2012. (See Additional Resources on page 13.)

The list of the three largest small group products in each state is based on enrollment data collected through HealthCare.gov. You should confirm with your state's insurance department that these data are consistent with your state's own enrollment data. It's important to note that a health insurance product is not exactly the same as a health plan, which is a specific combination of benefits and cost-sharing. This list of the three largest small group products should serve as an approximation of the benefit package of the potential small group benchmark plans in your state. It will be up to your state to identify the largest small group plans (by enrollment) offered by each of these three products that are potential benchmark plans.

Ask your state's insurance department if it has identified the potential benchmark plans in your state and, if so, what they are. You will want as much identifying information for the plans as possible. Once you have identified your state's potential benchmark plans, you need to obtain detailed information describing the benefits offered in each of these plans. For each plan, you need to know:

- Services and medical supplies and equipment covered,
- Drugs covered, sorted by drug category and class,
- Any duration limits placed on benefits,

- Any qualitative limits placed on benefits, such as prior authorization or step therapy requirements,
- Any dollar limits placed on benefits, and
- Any exclusions placed on benefits.

Typically, this detail of information is found in a plan's evidence of coverage, also called certificate of coverage, and in other detailed plan documents. Obtaining a plan's evidence of coverage is not always easy. You can ask an insurance plan directly for a copy of its evidence of coverage, or you can ask your state's insurance department if it has access to and could share these documents. If you cannot obtain detailed plan documents, you can at least obtain a general overview of the benefits covered by the three largest small group products in your state on [healthcare.gov](https://www.healthcare.gov).

Some states have already completed, or are in the process of completing, a comparative analysis of the benefits in their benchmark plan options. These analyses can be useful in understanding the scope of benefits in each plan, but the level of detail in these analyses can vary by state. Find out if your state has completed or is planning to complete an analysis of its benchmark plan options. If your state has already completed an analysis of benchmark plans, you should try to identify if there are any gaps in the analysis that still need to be filled. For example, does it provide information on duration and dollar limits placed on benefits for each of the plans? Does it include an analysis of benefit exclusions in each of the plans? These are all important pieces of information that you need to know when assessing benchmark plan options. If your state is in the planning stages of analyzing its benchmark options, see if there is a way for you to provide input on what types of benefit information need to be included in the analysis.

In addition, HHS recently issued a proposed rule that would require small group plans that are potential benchmark plans in each state to provide HHS with data on their health benefits, treatment limitations, drug coverage, and enrollment. However, it is unclear when this information would be collected and when it would be made publicly available. As such, it is important to attempt to obtain as much plan information as possible on your own.

If you think your state is likely to passively adopt the default benchmark plan, focus on identifying and obtaining as much information as possible on the largest plan by enrollment in the largest small group insurance product in your state.

Defining Your State's Essential Health Benefits Package

Select a benchmark plan

The state will choose from 10 state-specific benchmark plans. A state's selected benchmark plan will:

- Largely define what services will be covered under each of the 10 benefit categories the essential health benefits package is required to cover.
- Determine what limits, including day and visit limits and prior authorization requirements, could be included in the essential health benefits package.



Advocates:

You should advocate for your state to adopt the most comprehensive benchmark plan, in order to ensure that the essential health benefits meet the health needs of diverse populations.

+ Supplement with additional benefits

If a state's benchmark plan does not provide coverage for one or more of the 10 benefit categories, it will have to be supplemented with another plan's benefits for that category of service.



Advocates:

If a state's benchmark plan does not include coverage for certain services or supplies that are essential to care for a certain population, you should advocate that the essential health benefits package be supplemented with additional coverage to ensure it does not discriminate against this group.

— Remove discriminatory benefits and limits

A state's benchmark plan may include restrictive limits on coverage that discriminate against the health needs of certain populations and violate the requirements of the Affordable Care Act.



Advocates:

Advocate that any discriminatory benefit limits included in your state's benchmark plan be removed from the essential health benefits package.

■ **Key Questions to Ask When Analyzing a Benchmark Plan**

The following are some key questions that can be useful for assessing the comprehensiveness of benefits offered in each plan. When thinking through these questions, it may be helpful to apply a plan's benefits to people with specific health conditions to evaluate whether such a plan would adequately meet their health care needs.

- Are any essential services or medical supplies and equipment in the 10 required essential health benefits categories not covered in the benchmark plan?
- Are there any gaps in the benchmark plan's drug coverage, such as no coverage for injectible drugs?
- Are there any restrictive limitations placed on coverage of essential services, either day or visit limits, dollar limits, or restrictive prior authorization requirements?
- Can you demonstrate that any observed gaps in coverage or limitations on coverage are discriminatory?

While a state's essential health benefits package is based on an existing plan, it still has to meet all nondiscrimination requirements created by the Affordable Care Act. If a plan has restrictive limitations on coverage that could be discriminatory, you should advocate that those limits not be incorporated into the essential health benefits package. Similarly, if a plan does not cover certain services essential to a population, you should advocate that the essential health benefits package must be supplemented with additional coverage to ensure it does not discriminate against that group.

■ **Considering State-Mandated Benefits**

When considering whether a benchmark plan incorporates all state mandates, it is critical to not overlook the general comprehensiveness of a plan. A small group plan that is a benchmark plan option may incorporate the most state mandates. But if it offers generally less comprehensive benefits or has restrictive benefit limits compared to the other benchmark plan options, it may not be the best choice for your state. It's important to assess whether a plan offers adequate coverage across all categories of care and balance this with your assessment of what state mandates a plan covers.

It's also important to not automatically assume that a small group plan is the best option for incorporating all state mandates into the essential health benefits package. If your state has benefit mandates that apply only to individual market plans, there is no guarantee that a small group benchmark plan option offers coverage for those mandated services. Even if a small group plan is required to provide all state-mandated benefits, this does not mean another benchmark plan option does not already offer coverage for those same mandated services. You should see if other benchmark plan options with more comprehensive benefits already include coverage for a mandated service, despite not being required to offer it.

■ **Engaging in the Benchmark Plan Selection Process**

The first thing you need to determine is if your state will actively select its benchmark plan or if it is likely to passively adopt the default benchmark plan (the largest plan by enrollment in the largest small group insurance product in the state). If your state is going to actively pick a benchmark plan, find out what entity is responsible for making that decision and what the decision-making process will be. In some states, the benchmark plan may be selected at the executive level, by a state's insurance commissioner. Other states may require legislation to adopt a benchmark plan. Once you identify the selection process, see if there is an avenue for public input for you to voice concerns with certain benchmark plans and advocate for the most robust plan in your state.

If you think your state is likely to passively adopt the default benchmark plan, focus on analyzing the largest plan by enrollment in the largest small group insurance product in your state. If you identify benefit gaps or restrictions that you believe could be discriminatory or do not adequately cover the 10 required categories, try to submit comments and concerns with the default plan directly to HHS.

■ **Limit the Potential for Discriminatory Benefit Design in Your State**

HHS's proposal to give insurers benefit design flexibility could have serious negative consequences for consumers. Plans would be allowed to substitute benefits within essential health benefits categories and substitute dollar limits with day or visit limits. This type of flexibility could be used by plans to create discriminatory benefit designs that provide inadequate coverage for individuals with greater health care needs. This flexibility will also make it more difficult for families to compare plans when purchasing health coverage because they will not be assured a uniform set of benefits across the plans they are considering.

Additional guidance from HHS is needed to fully understand how much authority states have to limit their essential health benefits definition. Depending on future federal guidance, it may be that states will be able to outright prohibit insurers from substituting benefits within the essential health benefits package. Eliminating insurer flexibility would prevent plans from using benefit substitutions to create discriminatory benefit designs. This would not only be in the best interest of consumers, it would reduce administrative burden for the state because they would not have to review whether each plan's benefit substitutions still meet state and federal essential health benefits requirements, including nondiscrimination requirements.

If insurers are allowed the flexibility to substitute benefits and limits within the essential health benefits categories, it is important that states have a transparent and robust mechanism for reviewing substitutions to ensure that they are actuarially equivalent and not discriminatory in any way. As part of this review, insurance plans will need to file documents with their state's insurance department reporting any benefit substitutions they wish to make within each of the 10 categories of services in the essential health benefits package. Advocates should push states to make these plan documents public and open for comment. This will give consumers and advocates the opportunity to voice concerns that they have with proposed substitutions that could be discriminatory.

Regardless of whether states will have the authority to outright ban insurers from substituting benefits within the essential health benefits, states still have the option to create stronger benefit requirements for plans that want to be certified as qualified health plans (QHPs) sold in the exchange. A state could choose to prohibit at least qualified health plans from substituting benefits within the essential health benefits.

Conclusion

The essential health benefits package is intended to ensure that all individuals are guaranteed health coverage that meets their basic health needs. A state's benchmark plan will largely determine what services will be included in its essential health benefits package. Moving forward, advocates need to be actively involved in the process of defining their states' essential health benefits package to ensure it meets the diverse health care needs of individuals and families across their state.

Additional Resources on the Essential Health Benefits

For further discussion of issues raised in this guide, see the following resources:

Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (CCIIO) (December 16, 2011), available online at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

Frequently Asked Questions on Essential Health Benefits Bulletin, Department of Health and Human Services (HHS) (February 17, 2012), available online at <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.

Essential Health Benefits: List of the Largest Three Small Group Products by State, Center for Consumer Information and Insurance Oversight (CCIIO) (July 3, 2012), available online at <http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf>.

Proposed Rule on Data Collection to Support Standards Related to Essential Health Benefits, Department of Health and Human Services (HHS) (June 5, 2012), available online at <http://www.gpo.gov/fdsys/pkg/FR-2012-06-05/pdf/2012-13489.pdf>.

Drug Coverage in Essential Health Benefits Benchmark Plans: Formulary Analysis, Avalere Health LLC (January 2012), available online at http://www.avalerehealth.net/pdfs/Avalere_EHB_Formulary_Analysis.pdf.

Summary of Existing State Laws Mandating Health Benefits (as of December 2011), National Conference of State Legislatures, available online at http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx#State_list.

Additional Publications

Chapin White and Amanda E. Lechner, *State Benefit Mandates and National Health Reform* (Washington: National Institute for Health Care Reform, February 2012), available online at http://www.nihcr.org/State_Benefit_Mandates.pdf.

Cheryl Ulmer, John Ball, Elizabeth McGlynn and Shadia Bel Hamdounia, eds., *Essential Health Benefits: Balancing Coverage and Cost* (Washington: Institute of Medicine of the National Academies, October 2011), available online at http://www.nap.edu/catalog.php?record_id=13234.

Laura Skopec, Ashley Henderson, Susan Todd, and Pierre Yong, *Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans* (Washington: Office of Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, December 2011), available online at <http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml>.

Endnotes

¹ *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title I, Subtitle D, Section 1302.

² *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title I, Subtitle D, Section 1331 and Title II, Subtitle A, Section 2001.

³ *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title I, Subtitle A, Section 2711.

⁴ *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title I, Subtitle D, Section 1302.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title I, Subtitle D, Section 1311.

⁸ *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title I, Subtitle G, Section 1563.

⁹ *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title I, Subtitle D, Section 1302.

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