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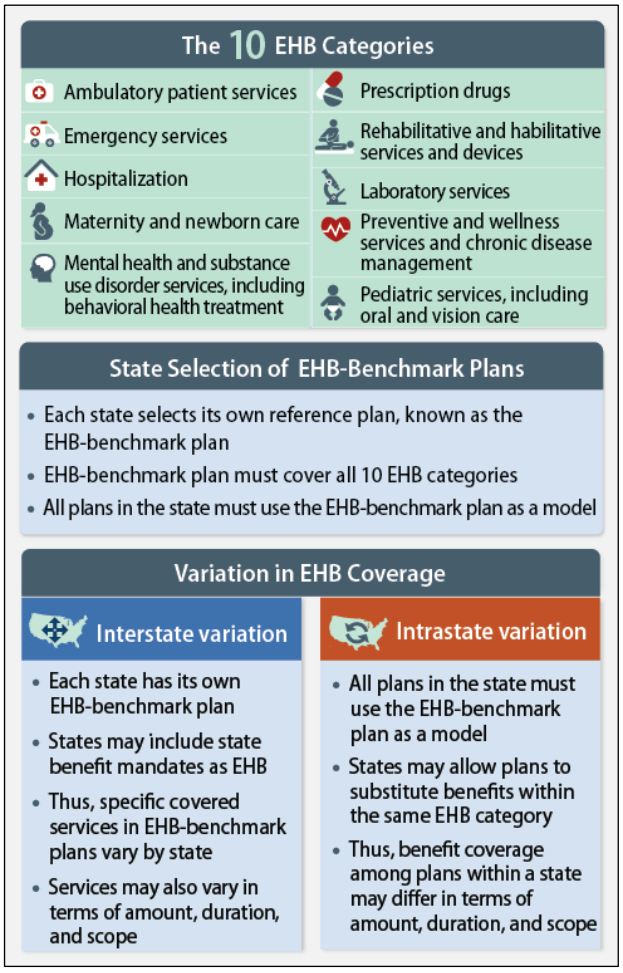
The Essential Health Benefits (EHB)

Overview

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) requires all non-grandfathered health plans in the non-group and small-group private health insurance markets to offer a core package of health care services, known as the *essential health benefits* (EHB). The ACA does not specifically define this core package. Instead, it lists 10 categories from which benefits and services must be included (see **Figure 1**) and requires the Secretary of the Department of Health and Human Services (HHS) to further define the EHB.

Figure 1. Overview of the EHB Process



Source: Congressional Research Service (CRS) analysis of the essential health benefit (EHB) process based on 45 C.F.R. §156.100-115.

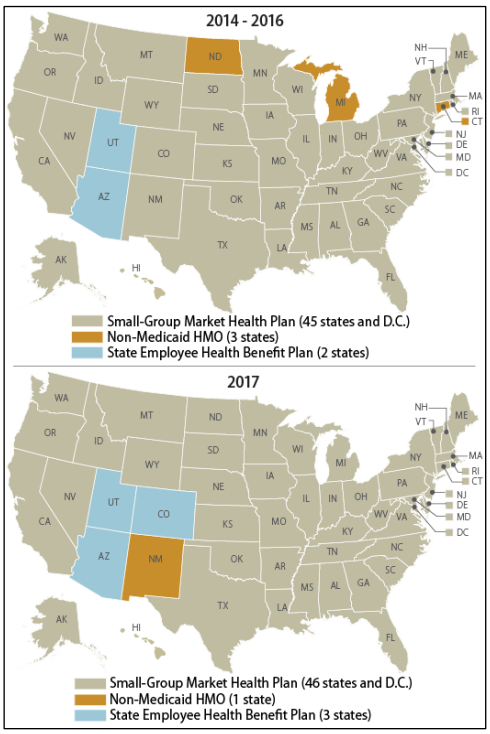
EHB for 2014-2017

State Selection of EHB-Benchmark Plans

The HHS Secretary outlined a process in which each state identified a single plan to serve as a reference plan on which most non-group and small-group market plans must base their benefits packages in terms of the scope of benefits offered (see **Figure 1**). These reference plans are known as *EHB-benchmark plans*.

For the 2014-2016 coverage years, the process required each state to select an EHB-benchmark plan that was based on plans available in the 2012 coverage year. For the 2017 coverage year, the process requires each state to update its EHB-benchmark plan based on plans available in the 2014 coverage year. A state selects a benchmark plan among (1) the state's small-group market health plans; (2) the state's state employee health benefit plans; (3) Federal Employees Health Benefits (FEHB) plans; or (4) the state's commercial non-Medicaid health maintenance organization (HMO). **Figure 2** maps the types of benchmark plans selected by each state.

Figure 2. State Selection of EHB-Benchmark Plans, 2014-2017



Source: CRS analysis of individual state EHB-benchmark plan summaries provided by the Centers for Medicare & Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans*, at http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html as of June 15, 2016.

Supplementing EHB-Benchmark Plans

According to the regulations, the EHB-benchmark plan had to provide coverage for all 10 EHB categories. If the selected benchmark plan did not include items or services within a category, the plan had to be supplemented.

Generally, if an EHB-benchmark plan did not cover 1 or more of the 10 EHB categories, the state supplemented the EHB-benchmark plan by adding that particular category in its entirety from another benchmark plan option.

Inclusion of State Benefit Mandates

Prior to the passage of the ACA, many states had laws, known as *state benefit mandates*, that required health plans to cover certain health care services, health care providers, and/or dependents. A state may require non-group and small-group plans to cover these state benefit mandates in addition to the EHB. Moreover, any state benefit mandates enacted on or before December 31, 2011, are considered to be part of the EHB.

Nonetheless, in addition to covering the EHB, states may choose to impose additional benefit mandates. If a state decides to impose additional benefits, the state itself must defray the cost of those benefits for plans offered in the *health insurance exchanges* (i.e., marketplaces in which individuals and small businesses can shop for and purchase private health insurance coverage).

Variation in EHB Coverage

Because each state selects its own EHB-benchmark plan, there is considerable variation in EHB coverage from state to state. This variation occurs in terms of specific covered services as well as in terms of amount, duration, and scope. For example, some state EHB-benchmark plans may include bariatric surgery as a covered service whereas other state EHB-benchmark plans may not cover bariatric surgery.

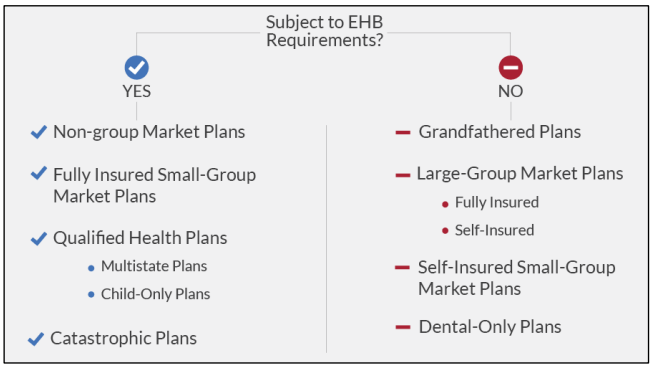
In addition to EHB variation by state, benefit coverage among plans within a state may differ. States may allow non-group and small-group market plans that offer the EHB to substitute benefits. A benefit may be substituted if the substitution is equivalent to the benefit being replaced and is made within the same EHB category. For example, a plan could offer coverage of up to 10 physical therapy visits and up to 20 occupational therapy visits as a substitute for EHB-benchmark plan coverage of up to 20 physical therapy visits and 10 occupational therapy visits, assuming other criteria are met.

Applicability of EHB Requirements to Health Plans

Generally, non-group and small-group market health plans are required to offer the EHB. This requirement applies to non-group and small-group plans offered both inside and outside the exchanges. Additional plan types are subject to the EHB; examples of these plan types include qualified health plans (e.g., multistate plans or child-only plans) and catastrophic plans (see **Figure 3**).

Certain health plans are not subject to the EHB requirements. For example, *grandfathered health plans* (health insurance plans that were in existence and in which at least one person was enrolled on the date of the ACA's enactment) are not subject to the EHB requirements as long as they maintain their grandfathered status. This exclusion includes non-group and small-group grandfathered health plans (see **Figure 3**).

Figure 3. Applicability of EHB Requirements to Health Plans



Source: CRS analysis of 42 U.S.C. §18021 and 42 U.S.C. §18022.

Notes: This figure is not an exhaustive list of existing plan types. Limited exceptions may apply.

EHB and Other ACA Provisions

Cost Sharing

The ACA imposes an annual cap on consumer cost sharing for the EHB. The ACA specifies that the limits work in two ways: they prohibit (1) applying deductibles to preventive health services and (2) annual out-of-pocket limits that exceed existing limits in the tax code. The cost-sharing limits apply only to in-network benefits. In 2016, the cost-sharing limits are $6,850 for an individual plan and $13,700 for a family plan. For 2017, the cost-sharing limits are $7,150 for an individual plan and $14,300 for a family plan.

Lifetime and Annual Dollar Limits

Prior to the ACA, plans generally were able to set *lifetime* and *annual limits*—dollar limits on how much the plan would spend for covered health benefits either during the entire period an individual was enrolled in the plan (lifetime limits) or during a plan year (annual limits). The ACA prohibited both lifetime and annual limits on the EHB. Plans are permitted to place lifetime and annual limits on covered benefits that are not considered EHB, to the extent that such limits are permitted by federal and state law.

Minimum Essential Coverage

The EHB requirement differs from *minimum essential coverage*. Minimum essential coverage is a term defined in the ACA and its implementing regulations that refers to the *individual mandate*, or the ACA requirement that most individuals must have health insurance coverage for themselves and their dependents or potentially pay a penalty for noncompliance. The definition of minimum essential coverage does not refer to minimum benefits but rather includes most private and public coverage.

For additional information, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*, by Namrata K. Uberoi.

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