

The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)

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Summary

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 but rather lists 10 benefit categories from which benefits and services must be included.

The 10 benefit categories are as follows:

- 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 and chronic disease management; and
- pediatric services, including oral and vision care.

For the 2014-2017 coverage years, each state was required to select an EHB-benchmark plan. The benchmark plan serves as a reference plan on which non-group and small-group market plans must substantially base their benefits packages.

Because states select their own EHB-benchmark plans, 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. State benefit mandates also may be considered to be part of that state's EHB and thus add to state-level coverage differences.

Furthermore, because states can allow non-group and small-group plans to substitute certain services within the categories, coverage in plans within a state also may vary by benefit amount, duration, and scope. For example, a state's EHB-benchmark plan could offer up to 20 physical therapy visits and 10 occupational therapy visits. Another plan in the state could offer coverage consistent with the EHB-benchmark plan by covering up to 10 physical therapy visits and 20 occupational therapy visits.

In addition to covering the EHB, the ACA imposes a limit on cost sharing (which includes co-payments, coinsurance, and deductibles) for the EHB. The ACA also prohibits plans from applying lifetime and annual dollar limits on the EHB.

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The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) includes many provisions that apply to health plans offered in the private health insurance market. The private market often is described as having three segments: the non-group,¹ small-group, and large-group markets;² and many of the ACA's provisions focus specifically on the non-group and small-group insurance markets. These reforms are intended to address perceived failures in those markets, such as limited access to coverage and higher costs of coverage relative to the large-group market plans, and to provide some parity with the large-group market.³ For example, benefit coverage in non-group and small-group market health plans generally was perceived to be limited in comparison to benefit coverage in large-group market health plans. Thus, to provide some similarity to plans in the large-group market, the ACA requires non-group and small-group health plans to offer the essential health benefits (EHB), which is a core package of health care services.

The EHB are one of the three components of the EHB package. The EHB package requires plans to (1) cover certain benefits (i.e., the essential health benefits); (2) comply with specific cost-sharing limitations; and (3) meet a certain generosity level.⁴

This report provides an overview of the first component of the EHB package—the essential health benefits. The report examines how the EHB are defined, regulations related to the EHB, state variation in the EHB, applicability of the EHB to health plans, and how the EHB interact with other ACA provisions.

Essential Health Benefits

Since 2014, all non-grandfathered⁵ plans in the non-group and small-group⁶ markets are required to offer a core package of health care services, known as the EHB. The ACA does not specifically define this core package. Instead, it lists 10 benefit 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.⁷

The HHS Secretary has the purview to define and periodically update the EHB. However, in defining the EHB, the HHS Secretary must take a number of parameters into account.⁸ For example, the scope of the EHB is to be equivalent to the scope of benefits typically provided under an employer-sponsored insurance plan. To accomplish this task, the ACA requires the Secretary of the Department of Labor (DOL) to conduct surveys of employer-sponsored

¹ The non-group (also known as the *individual*) market is where individuals can purchase health coverage directly from an insurer.

² Prior to the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), most states defined *small* as businesses having 50 or fewer employees. Under the ACA, the definition of *small* was set to expand to businesses having 100 or fewer employees beginning in 2016. However, President Obama signed into law the Protecting Affordable Coverage for Employees Act (PACE Act; P.L. 114-60) to rescind the ACA's expanded definition of *small* subject to the rules of the small-group market in the state.

³ For more information on the ACA's private health insurance provisions, see CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Namrata K. Uberoi.

⁴ 42 U.S.C. §18022.

⁵ For information on what constitutes a grandfathered plan, see the "Grandfathered Plans" section of this report.

⁶ Self-insured small-group market health plans are not required to cover the essential health benefits (EHB). For information on what constitutes a self-insured plan, see the "Self-Insured Plans" section of this report.

⁷ 42 U.S.C. §18022.

⁸ *Ibid.*

insurance plans to determine typical benefits and provide a summary of the findings to the HHS Secretary.

Figure 1. The 10 Essential Health Benefits Categories

 ESSENTIAL HEALTH BENEFITS
• 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

Source: 42 U.S.C. §18022.

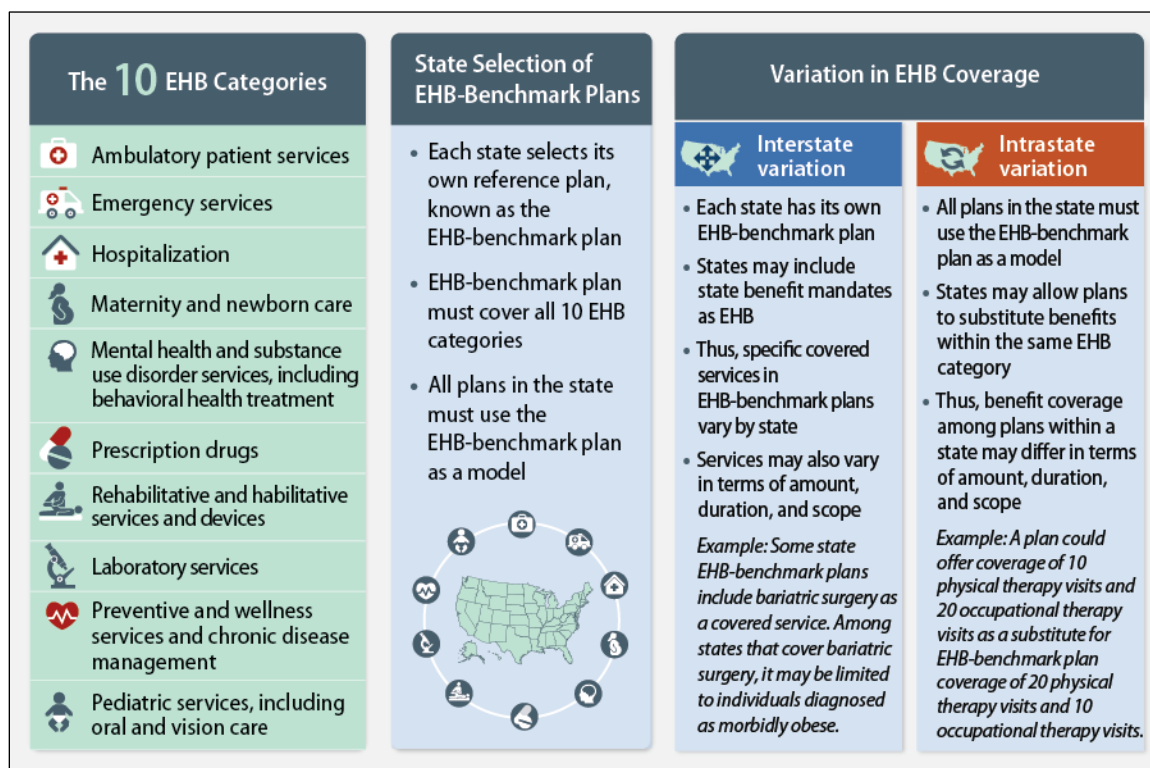
The EHB are to be balanced among the 10 categories, without a weighted preference toward any category. The HHS Secretary cannot make any coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life. Furthermore, the HHS Secretary must take into account the diverse health care needs of the population, which includes women, children, persons with disabilities, and other groups.

The HHS Secretary is tasked with reviewing the EHB, and part of the EHB review process includes providing a report to Congress and the public. The report is supposed to assess whether enrollees are facing any difficulty accessing services, either due to coverage or cost, and to consider whether the EHB need to be modified or updated due to changes in medical evidence or scientific advancement. If any modifications are to be made, the HHS Secretary is to include in the report how the EHB would be modified. Consequently, the Secretary periodically may update the EHB based on issues identified during the review process.⁹

⁹ Ibid.

Essential Health Benefits for 2014-2017

Figure 2. Overview of the Essential Health Benefits (EHB) Process



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

State Selection of Benchmark Plans

In December 2011, the Centers for Medicare & Medicaid Services (CMS) released a bulletin that outlined a reference plan approach for the EHB.¹⁰ This approach was based on employer-sponsored coverage in the current market. To define the EHB, HHS considered findings from the DOL's report¹¹ that described the scope of benefits under a typical employer-sponsored plan. HHS also considered a report¹² from the Institute of Medicine that recommended criteria and methods for determining and updating the EHB.

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 2**).¹³ These reference plans are

¹⁰ Centers for Medicare & Medicaid Services (CMS), *Essential Health Benefits Bulletin*, December 16, 2011, at https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

¹¹ Department of Labor, *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services*, April 15, 2011, at <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf>.

¹² Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost*, October 6, 2011, at <https://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>.

¹³ For more information, see the "Variation in Essential Health Benefits Coverage" section of this report.

known as *EHB-benchmark plans*. The benchmark selection approach identified by the Secretary applied for the 2014, 2015,¹⁴ 2016,¹⁵ and 2017¹⁶ coverage years. Each state's EHB-benchmark plan applied to non-grandfathered health plans offered in the non-group and small-group¹⁷ markets, both inside and outside the exchanges¹⁸ (also known as *marketplaces*).

For the 2014-2016 coverage years, the process required each state¹⁹ to select an EHB-benchmark plan 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. States select a benchmark plan among the following four options:

1. *Small-group market health plan*. Any of the three largest small-group market health plans, by enrollment, in that state;²⁰
2. *State employee health benefit plan*. Any of the three largest employee health benefit plan options, by enrollment, available to state employees in that state;
3. *Federal Employees Health Benefits (FEHB) plan*. Any of the three largest national FEHB plan options, by aggregate enrollment;²¹ or
4. *Non-Medicaid Health Maintenance Organization (HMO)*. The largest insured commercial non-Medicaid HMO, by enrollment, operating in that state.

¹⁴ The EHB-benchmark approach for the 2014 and 2015 coverage years was finalized in regulation. For more information, see Department of Health and Human Services (HHS), "Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," 78 *Federal Register* 12834-12872, February 25, 2013.

¹⁵ The general approach and benchmark selection for the 2016 coverage year did not change from the previous final rule. This continuity in approach was not stated explicitly. However, the Congressional Research Service confirmed with HHS that the benchmark selection for the 2016 coverage year had not changed. For more information, see HHS, "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016," 80 *Federal Register* 10750-10877, February 27, 2015.

¹⁶ The EHB-benchmark approach for the 2017 coverage year was finalized in regulation. HHS, "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016," 80 *Federal Register* 10750-10877, February 27, 2015.

¹⁷ See footnote 6 for exception for self-insured small-group market health plans.

¹⁸ The exchanges are marketplaces in which individuals and small businesses can shop for and purchase private health insurance coverage. The ACA requires all states to have two exchanges: (1) an individual exchange and (2) a small business health options program (SHOP) exchange. For more information on the health insurance exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*, coordinated by Namrata K. Uberoi.

¹⁹ HHS initially used the Public Health Service Act (PHSA; 78-410) definition of *state* for new PHSA requirements and funding opportunities included in Title I of the ACA. Under this definition, the new market reforms (including coverage of the EHB) in the ACA applied to the U.S. territories (Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands). However, in a letter to the U.S. territories, HHS subsequently determined that U.S. territories do not meet the definition of *state* for purposes of certain market reforms (e.g., EHB). For more information, see <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf>. This interpretation applied prospectively as of July 2014.

²⁰ 45 C.F.R. §156.100. For the 2014-2016 coverage years, a list of these products by state can be found at CMS, *Essential Health Benefits: List of the Largest Three Small Group Products by State*, July 3, 2012, at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/largest-smgroup-products-7-2-2012.pdf>. For the 2017 coverage year, a list of these products can be found at CMS, *Essential Health Benefits: List of the Largest Three Small Group Products by State*, April 8, 2015, at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/largest-smgroup-products-4-8-15-508d-pdf-Adobe-Acrobat-Pro.pdf>.

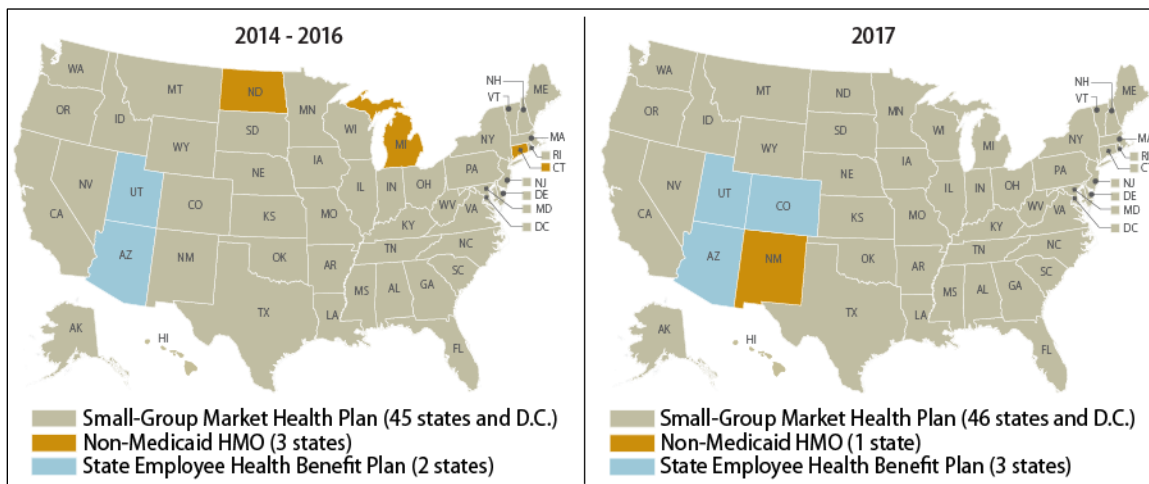
²¹ Ibid.

If a state does not make a selection, the default EHB-benchmark plan is the largest health plan, by enrollment, in that state's small-group market.²²

For 2014-2016, each state's benchmark plan was finalized in early 2013. **Figure 3** maps the type of benchmark plan selected by each state. The EHB-benchmark plan for 45 states and the District of Columbia (DC) is the small-group market health plan. Three states selected a non-Medicaid HMO, and two states selected a state employee health benefit plan as their EHB-benchmark plans. No state selected an FEHB plan as its benchmark plan.²³

For 2017, each state's benchmark plan was finalized in late 2015. **Figure 3** maps the type of benchmark plan selected by each state. The EHB-benchmark plan for 46 states and DC is the small-group market health plan. One state selected a non-Medicaid HMO, and three states selected a state employee health benefit plan as their EHB-benchmark plans. No state selected an FEHB plan as its benchmark plan.²⁴

Figure 3. State Selection of Essential Health Benefits Benchmark Plans



Source: CRS analysis of individual state EHB-benchmark plan summaries provided by 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.

Notes: No state selected a Federal Employees Health Benefits (FEHB) plan as its essential health benefits benchmark plan. HMO = health maintenance organization.

Coverage in Each Benefit Category

According to the regulations, the EHB-benchmark plan had to provide coverage for all 10 EHB categories. However, a number of state benchmark plans did not include all 10 EHB categories. If the selected benchmark plan did not include items or services within a category, the plan had to be supplemented accordingly.²⁵

²² In the 2014 and 2015 coverage years, when non-group and small-group market health plans in U.S. territories were required to cover the EHB, the default EHB-benchmark plan for U.S. territories was the largest Federal Employees Health Benefits (FEHB) plan.

²³ For more information on each state's EHB-benchmark plan, see benchmark plan summary information provided by CMS, "Information on Essential Health Benefits (EHB) Benchmark Plans," at <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>.

²⁴ Ibid.

²⁵ 45 C.F.R. §156.110.

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 (i.e., the small-group market health plan, state employee health benefit plan, FEHB plan, or non-Medicaid HMO options described in “State Selection of Benchmark Plans,” above).

For states that did not select an EHB-benchmark plan and thus defaulted to an EHB-benchmark plan (the largest health plan, by enrollment, in that state’s small-group market), HHS, if necessary, supplemented the state’s EHB-benchmark plan. The default benchmark plan was supplemented in the following order: (1) the second-largest plan, by enrollment, in the state’s small-group market; (2) the third-largest health plan, by enrollment, in the state’s small-group market; and (3) the largest national FEHB plan by enrollment across states.

CMS also released additional guidance for certain EHB categories. In a December 2011 bulletin,²⁶ CMS noted that of the 10 EHB categories, 3 categories were lacking under “typical employer plans.” These three categories were pediatric oral and vision services, habilitative services, and mental health and substance use disorder services. To address these issues, CMS outlined a separate supplemental process for pediatric oral and vision services and a separate determination process for habilitative services. Furthermore, CMS released additional guidance in regard to mental health and substance use disorder and prescription drug services.

Pediatric Oral and Vision Services

HHS outlined separate guidelines for supplementing pediatric oral and vision services. An EHB-benchmark plan that does not cover the pediatric oral and vision category is to be supplemented by adding the pediatric oral and/or vision services from either (1) the Federal Employees Dental and Vision Insurance Program (FEDVIP) plan with the largest national enrollment or (2) the benefits from a state’s separate Children’s Health Insurance Program (CHIP)²⁷ plan with the highest enrollment, if a separate CHIP plan exists.²⁸

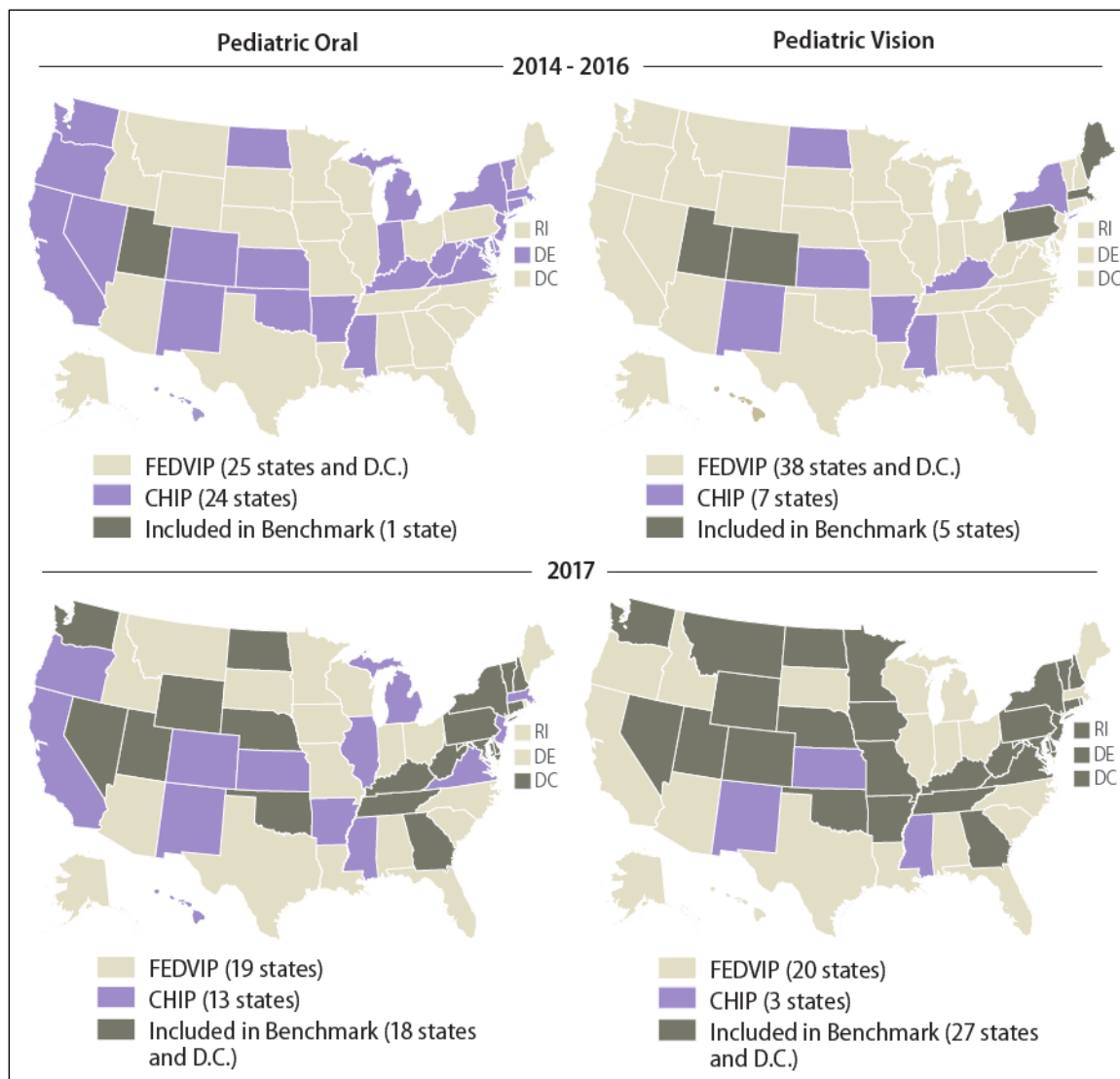
For the 2014-2016 coverage years, 49 states and DC had to supplement their EHB-benchmark plans for pediatric oral services—25 states and DC selected a FEDVIP plan, and 24 states selected a CHIP plan as their supplementary plan type (see **Figure 4**). For pediatric vision services, 45 states and DC had to supplement their EHB-benchmark plans; 38 states and DC selected a FEDVIP plan, and 7 states selected a CHIP plan as their supplementary plan type (see **Figure 4**).

For the 2017 coverage year, 32 states have to supplement their EHB-benchmark plans for pediatric oral services. Of these, 19 states selected a FEDVIP plan and 13 states selected a CHIP plan as their supplementary plan type (see **Figure 4**). For pediatric vision services, 23 states had to supplement their EHB-benchmark plans; of these, 20 states selected a FEDVIP plan and 3 states selected a CHIP plan as their supplementary plan type (see **Figure 4**).

²⁶ CMS, *Essential Health Benefits Bulletin*, December 16, 2011, at https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

²⁷ States may design their Children’s Health Insurance Programs (CHIP) in three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach in which the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. CHIP benefit coverage and cost-sharing rules depend on program design. For separate CHIP programs, the benefits are permitted to look more like private health insurance and states may impose cost sharing, such as premiums or enrollment fees.

²⁸ 45 C.F.R. §156.110.

Figure 4. State Selection of Supplementary Plan Types for Pediatric Oral and Vision Services

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

Notes: FEDVIP = Federal Employees Dental and Vision Insurance Program. CHIP = Children's Health Insurance Program.

Habilitative Services

HHS found that many employer-sponsored plans did not identify habilitative services as a distinct group of services.²⁹ Thus, in determining habilitative services, HHS proposed policies for coverage of such services.

²⁹ Laura Skopec, Ashley Henderson, and Susan Todd, et al., *Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans*, HHS, December 2011, at <http://aspe.hhs.gov/health/reports/2011/marketcomparison/rb.pdf>.

For the 2014 and 2015 coverage years, the HHS policies allowed states to define the benefits if the EHB-benchmark plan did not include coverage for habilitative services. If a state did not define habilitative services, either plans would have to cover habilitative services benefits that were similar in scope, amount, and duration to benefits covered for rehabilitative services or plans could determine their habilitative services benefits and report them to HHS for review.³⁰

For the 2016 coverage year, HHS modified the habilitative services benefits policy.³¹ Rather than allowing plans to cover habilitative services that are offered at parity with rehabilitative services, HHS adopted a uniform definition for habilitative services. Habilitative services are defined as follows:

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.³²

Although HHS adopted a definition, states may continue to define habilitative services so long as the state definition complies with EHB policies, including nondiscrimination. Plans, however, no longer may define habilitative services themselves. For the 2017 coverage year, nine states use the federal definition and two states use the state definition for habilitative services. The remaining 39 states and DC include habilitative services in their EHB-benchmark plans.

For the 2017 coverage year, HHS finalized additional guidance for habilitative services. HHS now requires plans to have separate visit limits on habilitative and rehabilitative services.³³

Mental Health and Substance Use Disorder Services

For non-group and small-group plans to be EHB compliant, the plans must provide mental health and substance use disorder services, including behavioral health treatment services. These services must be compliant with the Mental Health Parity and Addiction Equity Act (MHPAEA; P.L. 110-343, as amended), which generally requires health insurance coverage for mental health services to be offered on par with covered medical and surgical benefits.

Prescription Drug Services

As part of the EHB, HHS outlined additional requirements regarding prescription drug services. Non-group and small-group market plans must cover *at least* the greater of (1) one drug in every United States Pharmacopeia (USP) category or class or (2) the same number of prescription drugs in each category and class as the EHB-benchmark plan.³⁴

For the 2016 coverage year, HHS finalized additional guidance for the drug exceptions process and formulary drug lists.³⁵ HHS outlined a drug exceptions process for enrollees to request and gain access to clinically appropriate drugs that are not covered by their health plan. The process

³⁰ HHS, “Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,” 78 *Federal Register* 12834-12872, February 25, 2013.

³¹ HHS, “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016,” 80 *Federal Register* 10750-10877, February 27, 2015.

³² *Ibid.*

³³ 45 C.F.R. §156.115.

³⁴ 45 C.F.R. §156.122.

³⁵ *Ibid.*

takes 72 hours for a standard exception and 24 hours for an expedited review request. If the exception is granted, the plan must treat the drug as an EHB, including counting any cost sharing³⁶ toward the plan's annual cost-sharing limits.³⁷ For 2016, plans must have an up-to-date, accurate, and complete formulary drug list,³⁸ which must include price tiers, on their websites.³⁹ The formulary must be easily accessible to plan enrollees, prospective enrollees, the state, the exchange, HHS, the U.S. Office of Personnel Management (OPM), and the general public.

For the 2017 coverage year, HHS requires plans to use a pharmacy and therapeutics (P&T) committee⁴⁰ system in addition to the current standard. The P&T committees will develop formulary drug lists that cover prescription drugs across a broad range of therapeutic categories and classes and that do not discourage enrollment by any group of consumers. The P&T committees also will have to review and approve plan policies that affect consumer access to drugs.⁴¹

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. Examples of state benefit mandates include coverage for substance abuse treatment, chiropractors, or adopted children. 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.⁴²

Nonetheless, in addition to covering the EHB, states may choose to impose additional benefit mandates.⁴³ However, if a state does decide to impose additional benefits, the state itself must defray the cost of those benefits for plans offered in the exchange. The state must make a payment either to the enrollee or directly to the plan on behalf of the enrollee for all plans, regardless of whether an individual is receiving financial assistance.⁴⁴ The plan quantifies the cost of the additional benefits. The cost calculation is based on analysis in accordance with generally accepted actuarial principles and methodologies, is conducted by a member of the American Academy of Actuaries, and is reported to the exchange by the plan.

³⁶ *Cost sharing* is the share of costs an insured individual pays for services; the term often includes deductibles, coinsurance, and co-payments. A *deductible* is the amount an insured individual pays before his or her health insurance issuer begins to pay for services. *Coinsurance* is the share of costs, figured in percentage form, an insured individual pays for a health service. A *co-payment* is a fixed amount an insured individual pays for a health service.

³⁷ For information on the annual limits on cost sharing, see the "Cost Sharing" section of this report.

³⁸ A formulary is a list of drugs that a plan chooses to cover and the terms under which those drugs are covered.

³⁹ Health insurance plans may assign formulary drugs to price tiers that correspond to different levels of cost sharing.

⁴⁰ The pharmacy and therapeutics committee is a committee that meets to decide which drugs will appear on a health insurance plan's drug formulary.

⁴¹ 45 C.F.R. §156.122.

⁴² 45 C.F.R. §155.170.

⁴³ *Ibid.*

⁴⁴ Persons who obtain coverage through the individual exchange may be eligible for financial assistance from the federal government. Eligibility for such assistance is based on income and provided in the form of premium tax credits and cost-sharing subsidies. For more information, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*, by Bernadette Fernandez.

Variation in Essential Health Benefits Coverage

Interstate Variation

Because states select their 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, among states that cover bariatric surgery as an EHB, the amount, scope, and duration of the service may vary. For example, the service may be limited to individuals diagnosed as morbidly obese in one state and limited to individuals for whom the service was deemed medically necessary in another state. Additional discussion and illustrative examples of coverage variation from state to state for selected services can be found in **Table 1**. State benefit mandates also may be considered to be part of that state's EHB and thus add to state-level coverage differences.

Intrastate Variation

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 actuarially⁴⁵ equivalent to the benefit being replaced⁴⁶ and is made within the same EHB category.⁴⁷ 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 actuarial equivalence and the other criteria are met.⁴⁸ Substitutions, however, cannot be made for prescription drug benefits.

⁴⁵ Actuarial value is a summary measure of a plan's generosity of coverage, expressed as a percentage of medical expenses for a standard population and a set of allowed charges estimated to be paid by the issuer. In other words, actuarial values reflect the relative proportions of cost sharing that may be imposed. On average, the lower the actuarial value of a plan, the greater the cost sharing for the enrollee.

⁴⁶ The substitutions are based on standards set forth in CHIP regulations at 42 C.F.R. §457.431.

⁴⁷ 45 C.F.R. §156.115.

⁴⁸ HHS, CMS, *Frequently Asked Questions on Essential Health Benefits*, February 2012.

Table 1. Illustrative Examples of Coverage Variation in State Essential Health Benefits Benchmark Plans for Selected Services

Service	Variation
Bariatric Surgery	Almost a quarter of state EHB-benchmark plans provide coverage for bariatric surgery. Among state benchmark plans that do cover bariatric surgery services, the coverage itself varies by state. Many state benchmark plans limit bariatric surgery to individuals diagnosed as morbidly obese or to individuals for whom the service was deemed medically necessary. Some benchmark plans require precertification. Moreover, plans may exclude certain procedures.
Chiropractic Care	A majority of state EHB-benchmark plans provide coverage for chiropractic care. Chiropractic care coverage varies by benefit amount, ranging from 10 visits to 40 visits per year (with certain exclusions). Some state benchmark plans combine chiropractic care visit limits with rehabilitative, habilitative, occupational therapy, physical therapy, and acupuncture benefit limits.
Infertility Treatment	Fewer than a quarter of state EHB-benchmark plans provide coverage for infertility treatment services. The benefit scope varies by benchmark plans. For example, some plans exclude artificial insemination and in vitro fertilization, whereas other plans only cover in vitro fertilization. Some plans may cover treatment for underlying causes of infertility only.

Source: CRS analysis of individual state 2017 EHB-benchmark plan summary information provided by 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.

Note: Examples provided in this table are for illustrative purposes only.

Applicability of Essential Health Benefits Requirements to Health Plans

Health Plans Subject to Essential Health Benefits Requirements

Generally, non-group and fully insured 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 (see **Figure 5**).

Qualified Health Plans

The ACA generally requires that non-group and small-group health⁴⁹ insurance plans offered through exchanges are Qualified Health Plans (QHPs). Typically, to be certified as a QHP a plan has to offer the EHB, comply with cost-sharing limits, and meet certain market reforms. Each exchange is responsible for certifying the plans it offers. However, QHPs can be offered both inside the health insurance exchanges and outside the exchanges on the private health insurance market.⁵⁰ The exchanges also offer variants of QHPs such as multistate plans and child-only plans.

⁴⁹ There are non-group and small-group health plans offered outside the exchanges that are not QHPs. However, these plans are still required to cover the EHB.

⁵⁰ 42 U.S.C. §18021.

Figure 5. Applicability of Essential Health Benefits Requirements to Health Plans

Sources: 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.

Multistate Plans

The ACA directs OPM to contract with private insurers in each state to offer at least two⁵¹ comprehensive health insurance options, known as multistate plans (MSPs). MSPs are designed to offer nationally available QHPs through the exchanges; MSPs are not available outside the exchanges. Some MSP options also offer in-network⁵² care for out-of-state services, but not all do.

MSPs must offer a package of benefits that includes the EHB (see **Figure 1**). MSPs also must offer a package of benefits that is substantially equal to either the state-selected EHB-benchmark plan for the state in which the plan is offered or an OPM-selected benchmark plan.⁵³ Moreover, MSPs must comply with any state standards related to benefit mandates, substitution of benefits, and habilitative services.⁵⁴

Child-Only Plans

Child-only health insurance plans are a type of QHP available in the exchanges. To offer child-only plans in an exchange, a health insurance plan must also offer a QHP in the exchange. The ACA requires the plan to offer the child-only exchange plan at the same coverage level as the

⁵¹ One of the issuers must be nonprofit.

⁵² The facilities, providers, and suppliers with which a health plan has contracted to provide health care services.

⁵³ The Office of Personnel Management-selected EHB-benchmark plans are the three largest FEHB plan options. Recall that for the 2014-2017 coverage years, no state selected an FEHB plan as its state EHB-benchmark plan.

⁵⁴ 45 C.F.R. §800.105.

QHP.⁵⁵ Only individuals under the age of 21 may enroll in child-only exchange plans. Child-only health plans are treated as a type of QHP and thus are subject to EHB requirements.⁵⁶

Catastrophic Plans

Catastrophic plans are a type of health plan offered in the individual exchanges. Catastrophic plans offered through exchanges provide the EHB and coverage for at least three primary care visits. The monthly premium for catastrophic plans generally is lower than for other QHPs. However, catastrophic plans impose a very high deductible, and cost sharing generally is higher. These plans also do not meet the minimum requirements related to coverage generosity (i.e., actuarial value).⁵⁷ Catastrophic plans may be offered only in the individual market for (1) individuals under the age of 30 and (2) persons exempt from the ACA requirement to obtain health coverage because no affordable coverage is available or they have a hardship exemption.⁵⁸

Health Plans Not Subject to Essential Health Benefits Requirements

Certain health plans are not subject to the EHB requirements. Examples of these health plans include grandfathered plans, large-group market plans, self-insured plans, and dental-only plans (see **Figure 5**).

Grandfathered Plans

Health insurance plans that were in existence (in the non-group, small-group, or large-group market) and in which at least one person was enrolled on the date of the ACA's enactment (March 23, 2010) are considered grandfathered and have a unique status under the ACA. As long as a plan maintains its grandfathered status, the plan has to comply with some but not all ACA provisions. Grandfathered plans are not subject to the EHB requirements. Plans may lose their status if they apply certain changes to benefits, cost sharing, employer contributions, and access to coverage.⁵⁹

⁵⁵ Coverage level refers to actuarial value. See footnote 45 for an explanation of actuarial value.

⁵⁶ 42 U.S.C. §18022.

⁵⁷ While catastrophic plans technically do not meet the generosity requirements for coverage, a catastrophic plan may be considered as meeting such coverage generosity requirements so long as it meets the other catastrophic plan requirements described above.

⁵⁸ The ACA requires most individuals to have health insurance coverage or potentially to pay a penalty for noncompliance (i.e., the individual mandate). Some individuals are exempt from the mandate and the penalty. The ACA allows the HHS Secretary to grant hardship exemptions from the individual mandate penalty to anyone determined to have suffered a hardship with respect to the capability to obtain coverage. Examples of circumstances that would allow an individual to receive a hardship exemption include an individual not being eligible for Medicaid based on a state's decision not to carry out the ACA expansion and financial or domestic circumstances that prevent an individual from obtaining coverage. For more information, see CRS Report R41331, *Individual Mandate Under the ACA*, by Annie L. Mach.

⁵⁹ For information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

Large-Group Market Plans

Large-group market plans typically are employer-sponsored insurance plans and are defined by the number of employees. In general, a large-group plan has 50 or more employees.⁶⁰ Many of the market reform provisions in the ACA targeted the non-group and small-group markets. The reforms focused on perceived failures in these markets and provided parity with the large-group market. Accordingly, large-group plans are exempt from a number of ACA market reforms, including coverage of the EHB.⁶¹

Nonetheless, benefits and coverage offered in large-group market plans play an important role for the EHB. Recall that in defining the EHB, HHS examined the scope of benefits under a typical employer-sponsored insurance plan and used that information in determining what services would be covered as well as additional supplemental guidelines.

Self-Insured Plans

Self-insured plans are a type of group health plan. Organizations that self-insure do not purchase health coverage from insurance carriers. Self-insured plans refer to health coverage that is provided directly by the organization seeking coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering medical expenses. Firms that self-insure may contract with third-party administrators to handle administrative duties such as member services, premium collection, and utilization review. Self-insured plans are not subject to many of the ACA market reforms, including the EHB.

Dental-Only Plans

In the exchanges, an individual can obtain dental coverage as part of a QHP or as a stand-alone dental plan. Dental-only plans must provide coverage for pediatric oral services (1 of the 10 EHB categories). Dental-only plans are not required to cover the remaining EHB categories.⁶²

Essential Health Benefits 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 two⁶³ 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

⁶⁰ See footnote 2 for additional explanation.

⁶¹ For more information about the applicability of market reforms to health plans, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

⁶² 42 U.S.C. §18031.

⁶³ The ACA previously limited cost sharing in three ways. It also included deductible limits for plans offered in the small-group market—generally prohibiting these plans from having deductibles greater than \$2,000 for self-only coverage and \$4,000 for any other coverage in 2014. However, the Protecting Access to Medicare Act of 2014 (P.L. 113-93) repealed this provision, thereby removing the deductible limits for plans offered in the small-group market.

limits apply only to in-network benefits and must include all co-payments, coinsurance, and deductibles.⁶⁴

In 2016, the cost-sharing limits are \$6,850 for an individual plan and \$13,700 for a family plan.⁶⁵ For 2017, the cost-sharing limits are \$7,150 for an individual plan and \$14,300 for a family plan.⁶⁶

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 EHBs, to the extent that such limits are permitted by federal and state law.⁶⁷

Minimum Essential Coverage

The EHB 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*,⁶⁸ or the ACA requirement that most individuals must have health insurance coverage for themselves and their dependents or potentially pay a penalty for noncompliance.⁶⁹ The definition of minimum essential coverage does not refer to minimum benefits but rather includes most private and public coverage (e.g., employer-sponsored coverage, individual coverage, Medicare, and Medicaid, among others).⁷⁰

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⁶⁴ 45 C.F.R. §156.130.

⁶⁵ HHS, “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016,” 80 *Federal Register* 10750-10877, February 27, 2015.

⁶⁶ HHS, “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017,” 81 *Federal Register* 12204-12352.

⁶⁷ 42 U.S.C. §300gg–11.

⁶⁸ For more information, see footnote 58.

⁶⁹ 56 U.S.C. §5000A.

⁷⁰ For more information on minimum essential coverage see CRS Report R41331, *Individual Mandate Under the ACA*, by Annie L. Mach.

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