

Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California

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Beginning in 2014, the federal Patient Protection and Affordable Care Act (ACA) required that most plans sold in the individual and small group markets offer a comprehensive set of benefits, called Essential Health Benefits (EHBs).¹ The U.S. Department of Health and Human Services (HHS) established a process through which states could select a “benchmark plan” that covers the EHBs that must be included in the scope of benefits for each plan sold in the individual and small group markets of a given state. In 2018, HHS modified this process to provide states with greater flexibility to determine, update, or modify their existing benchmark plans.² This issue brief is part of a two-brief series produced by the California Health Benefits Review Program (CHBRP) that provides background on EHBs in California and how they may change in future years. This brief provides an overview of how EHBs are defined at the federal level and in California, including how HHS regulations allow a state to alter its selection of its benchmark plan and thus make some alterations to its definition of EHBs. This brief also notes how, in California, EHBs apply to some insurance coverage that is not associated with Covered California, the health insurance exchange (or “marketplace”) California established in accordance with the ACA.

See the companion issue brief, *Essential Health Benefits: Exceeding EHBs and the Defrayal Requirement*, for information on exceeding EHBs and the requirement for states to defray the costs of additional benefit mandates.³

¹ 42 U.S.C. § 18022

² 83 FR 16930, available at: <https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019>

³ See CHBRP’s companion issue brief, *Essential Health Benefits: Exceeding EHBs and the Defrayal Requirement*, available at: <https://www.chbrp.org/other-publications/issue-briefs>.

Health Insurance Subject to the Essential Health Benefits Coverage Requirement

The ACA requires coverage of EHBs for almost all enrollees in the individual and small-group markets, both inside and outside Covered California (Table 1).⁴ Inside Covered California, all qualified health plans (QHPs)⁵ are required to provide coverage of EHBs,⁶ while outside Covered California, nongrandfathered plans and policies in the individual and small-group market are required to cover EHBs.⁷ Large group, self-insured and grandfathered plans and policies are exempt from the EHB requirements.^{8,9} For 2024, CHBRP estimated that 12.1% of Californians are enrolled in commercial health insurance that must cover EHBs.¹⁰ Medi-Cal, California’s Medicaid program, is also required by the ACA to cover a set of benefits referred to as EHBs, but, as discussed in Appendix A, Medi-Cal EHBs are separate from and function independently from the EHBs that commercial health insurance can be required to cover under the ACA.

Table 1. Required Coverage of Essential Health Benefits (EHBs) in California for Privately Purchased Health Insurance

	Inside Covered California	Outside Covered California
Individual Market		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes
Small-Group Market		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes

Notes: (a) Qualified health plans cannot be grandfathered plans or policies, therefore there are not grandfathered plans or policies sold through Covered California.

Federal Requirements and Guidance

EHBs must include items and services in the following 10 benefit categories:¹¹

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health 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 and chronic disease management; and
10. Pediatric services, including oral and vision care.

⁴ 42 U.S.C. §18022.

⁵ Plans and policies certified and sold through the marketplace are called qualified health plans (QHPs). QHPs sold through Covered California, California’s insurance marketplace, are regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI), and thus are subject to the state’s benefit mandates.

⁶ 42 U.S.C. §18021.

⁷ 42 U.S.C. §300gg-6.

⁸ A grandfathered health plan is defined as: “A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers” (www.healthcare.gov/glossary/grandfathered-health-plan/).

⁹ The Affordable Care Act added certain market reform provisions to ERISA, making those provisions applicable to employment-based group health plans, providing additional protections for benefits under employment-based group health plans. They include extending dependent coverage to age 26; prohibiting preexisting condition exclusions for all individuals and prohibiting the imposition of lifetime and annual limits on essential health benefits.

¹⁰ See CHBRP’s resource, *Estimates of Sources of Health Insurance in California*, available at: <https://www.chbrp.org/other-publications>.

¹¹ 45 CFR § 156.110(a); 45 CFR § 156.111

When defining EHBs within the 10 EHB categories, the EHB floor must be “equal to the scope of benefits provided under a typical employer plan.”¹²

Selecting a Benchmark Plan

For plan years 2014 through 2019, states selected from four base-benchmark plan options¹³ that reflected the scope of services offered by a typical employer plan and then supplemented it to ensure it includes all 10 EHB categories and met the other ACA requirements (e.g., balance between the 10 EHB categories, nondiscrimination).¹⁴ A health plan or policy is required to offer benefits that are “substantially equal” to the benefits of the selected benchmark plan. Plans or policies could substitute coverage within a benefit category, with the exception of the prescription drug benefits category, so long as they do not reduce the value of coverage; the substituted benefits must be actuarially equivalent to the benefits being replaced. States can enforce stricter requirements on benefit substitution or prohibit it entirely.¹⁵

California selected the “largest plan by enrollment in any of the three largest small-group insurance products in the state’s small-group market” for its base-benchmark plan. For California, that was the Kaiser Foundation Health Plan Small Group HMO 30 plan, which was supplemented with additional benefits in order to meet the broad requirements of EHBs and equal the EHB-benchmark plan.¹⁶

HHS issued two *Notice of Benefit and Payment Parameters* final rules in 2018 and 2019, which contained a number of changes and updates, including some pertaining to benchmark plan selection.¹⁷ These rules provided new flexibility for states by allowing three new options for selecting a benchmark plan, in addition to the option of retaining the current benchmark plan, beginning with the 2020 plan year:

Option 1: Selecting the benchmark plan that another State used for the 2017 plan year.

Option 2: Replacing one or more categories of EHBs under its benchmark plan used for the 2017 plan year with the same category or categories of EHB from the benchmark plan that another State used for the 2017 plan year.

Option 3: Otherwise selecting a set of benefits that would become the State’s EHB-benchmark plan.

States must submit proposed modified benchmark plan selection by the first Wednesday in May two years prior to the effective date of the new benchmark plan (i.e. by May 2024 for plan year beginning in 2026).¹⁸

California’s benchmark plan selection has remained the same for subsequent plan years, including through 2023 when this brief was published.

¹² 42 U.S.C. §18021(b)(2)(A).

¹³ States could select a benchmark plan from the following options: the largest plan by enrollment in any of the three largest small-group insurance products in the state’s small-group market; any of the largest three state employee health benefit plans by enrollment; any of the largest three national Federal Employee Health Benefits Plan (FEHBP) options by enrollment; or the largest insured commercial non-Medicaid HMO operating in the state.

¹⁴ Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. *Federal Register*, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. Accessed August 27, 2019.

¹⁵ Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

¹⁶ Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services*. 2019. Available at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>

¹⁷ 83 FR 16930

¹⁸ 45 CFR § 156.111

Definitions

Base-benchmark plan: the plan selected by a State prior to any adjustments

EHB-benchmark plan (benchmark plan): the selected base-benchmark plan plus selected supplements in order to satisfy the EHB category requirements

Scope of Benefits

Each state's EHB-benchmark plan must still provide coverage for items and services within all 10 categories of benefits. The benchmark plan is also subject to the scope of benefits requirements that provide both a floor and ceiling. The five scope of benefits requirements include:

- 1) Scope of benefits equal to or greater than the scope of benefits provided under a typical employer plan, which is defined as either:
 - a) One of the state's 10 benchmark plan options, as sold in 2017
 - b) The largest health insurance plan by enrollment within one of the five largest group health insurance products in the state, provided that: (1) the product has at least 10% of the total enrollment of the 5 largest large group health insurance products in the state, (2) the plan provides a minimum value of 60% of total allowed cost of benefits, (3) the benefits are not excepted benefits (such as workers' compensation, disability income, liability and travel insurances) and (4) the benefits are from a plan year beginning in 2014 or later
- 2) Cannot exceed the generosity of the most generous among a set of comparison plans, including:
 - a) The state's benchmark plan utilized for the 2017 plan year
 - b) Any of the state's benchmark plan options for the 2017 plan year
- 3) Cannot have benefits unduly weighted towards any of the 10 categories of benefits
- 4) Must provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups
- 5) Cannot include discriminatory benefit designs that violate the non-discrimination standards (age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions)

While a state will confirm in writing that a selected benchmark plan option fulfills the above scope of benefits requirements, the state also must obtain actuarial certification that the benchmark plan meets the generosity floor but does not exceed the generosity ceiling. The certified actuarial report must affirm that the benchmark plan provides a scope of benefits equal to or greater than the typical employee plan (described in item 1 above) without exceeding the generosity of the most generous among the plans listed in item 2 above.

California's Selected EHB Benchmark Plan

The base-benchmark plan California selected for 2014 (Kaiser Foundation Health Plan Small Group HMO 30 plan) was the largest plan by enrollment in one of the three largest small-group insurance products in the state's small-group market.¹⁹ California chose to supplement this plan with the pediatric oral benefit from its separate CHIP program,²⁰ and the pediatric vision benefits from the FEDVIP plan to create the EHB-benchmark plan. If the selected base-benchmark plan did not include habilitative services, states or insurers were required to supplement the base-benchmark plan to cover this EHB category. California chose to define habilitative services²¹ and required that these services be provided "under the same terms and conditions applied to rehabilitative services."

In addition, the Kaiser Foundation Health Plan Small Group HMO 30 plan is a DMHC-regulated plan and, as such, is subject to the Knox-Keene Health Care Service Plan Act of 1975 that requires coverage of medically necessary basic

¹⁹ California Health & Safety Code 1367.005 and Insurance Code 10112.27.

²⁰ In 2014, California completed transitioning enrollees in Healthy Families, its Separate Children's Health Insurance Program (CHIP) program, into Medi-Cal, becoming a Medi-Cal Expansion CHIP program. The EHB pediatric oral benefits are based on the benefits covered in the Healthy Families Program in 2011–2012, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. (H&SC Section 1367.005; IC Section 10112.27)

²¹ California defined habilitative services as: "Habilitative services means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment." (H&SC Section 1367.005; IC Section 10112.27)

health care services. Therefore, medically necessary basic health care services are a part of the EHB coverage requirement in California.²²

In plan years 2014, 2015 and 2016, the base-benchmark plan was a plan that was sold in 2012, while in plan years 2017 through 2024, the base-benchmark plan was a plan that was sold in 2014.²³ As no new base-benchmark plan or supplements were submitted, the Kaiser Foundation Health Plan Small Group HMO 30 plan plus identified supplements continues to serve as the state's EHB-benchmark plan.

Essential Health Benefits and Annual Out-of-Pocket Maximums

The ACA places an annual limitation, or annual out-of-pocket maximum, on plans and policies required to provide coverage for EHBs.²⁴ The annual out-of-pocket maximum for 2023, as set by the federal government, is \$9,100 for self-only coverage or \$18,200 for family coverage, and includes deductibles, copayments, and other forms of cost sharing but does not include the cost of premiums.²⁵ In California, the annual out-of-pocket maximum may be lower depending on an enrollee's income and on the metal coverage level of the plan or policy.²⁶ The ACA allows the pediatric dental benefit to be covered either through a stand-alone dental insurance carrier or through an enrollee's health insurance carrier.²⁷ Further guidance from HHS has allowed stand-alone pediatric dental insurance to have a separate annual limit from the annual limit for health insurance.^{28,29}

The ACA also requires that "group health plans" adhere to this annual out-of-pocket maximum.³⁰ Although large-group market plans or policies are not subject to EHB coverage requirements in California at this time, federal guidance has clarified that the annual out-of-pocket maximum applies to the large group.³¹ In California, statute also requires nongrandfathered large group plans and policies that cover EHBs to maintain an annual out-of-pocket maximum that only applies to EHBs.³²

Potential Changes for Essential Health Benefits: California Options

In the future, California could choose to retain its current EHB-benchmark plan, or select one of the new options described above to alter its benchmark plan. By selecting some or all categories from another state's benchmark plan or adding to the base-benchmark plan, California could include new services not currently in California's benchmark plan. CHBRP is aware of three specific benefits that are covered by the majority of other state benchmark plans but that are not included in the current Kaiser Foundation Health Plan Small Group HMO 30 plan: chiropractic care services, hearing aids, and infertility services and treatments (most incorporating utilization management and other limits to these benefits).³³

²² Starting in 2014, CDI-regulated policies subject to the EHB coverage requirement—nongrandfathered small-group and individual market policies—were required to cover basic health care services.

²³ Details can be found here: <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf> and here: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_CA.zip.

²⁴ 42 U.S.C. §18022(c). This section references Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, which defines maximum annual out-of-pocket expenses for high deductible health plans (HDHPs).

²⁵ Available at: <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>.

²⁶ More information is available at: www.healthexchange.ca.gov/Pages/Default.aspx.

²⁷ 42 U.S.C. §18022 (d)(2)(B)(ii).

²⁸ Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

²⁹ For more information on the EHB pediatric oral and vision coverage requirement, standalone dental plans, and the annual limit requirements for these plans, see CHBRP's Policy Brief on this issue, available here: <https://www.chbrp.org/other-publications>.

³⁰ 42 U.S.C. §300gg-6.

³¹ Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

³² California Health & Safety Code 1367.006(2) and Insurance Code 10112.28(2).

³³ See the Cigna document, *Essential Health Benefits: Benchmark Plan Comparison 2021 and Later*, access on January 3, 2022, accessible at: <https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf>

Appendix A Medicaid and Essential Health Benefits

Since 2006, states have had the option to identify Medicaid benchmark plans for certain groups of enrollees under section 1937 of the Social Security Act.³⁴ The ACA renamed Section 1937 Medicaid benchmark or benchmark-equivalent plans “Alternative Benefit Plans” (ABPs), and specified that they must cover the 10 Essential Health Benefits (as defined in section 1302 of the ACA) to which some commercial health insurance, as specified earlier in this brief, is subject.³⁵ Adults in the Medicaid Expansion population (i.e. persons eligible under the “modified adjusted gross income standard”) must be covered under ABPs, and states may use an ABP for coverage of any other groups of individuals eligible for Medicaid, which is called Medi-Cal in California.³⁶

Section 1937 of the Social Security Act provides the following options for selection of ABPs:³⁷

- The benefit package provided by the Federal Employees Health Benefit plan (FEHB) Standard Blue Cross/Blue Shield Preferred Provider Option;
- State employee health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- (Federal Health and Human Services) Secretary-approved coverage, which is a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage.

The benefits included in California’s ABP (currently Blue Cross Blue Shield/CareFirst Preferred Option 1) are the same benefits as full-scope Medi-Cal benefits, discussed in Attachment 3.1-A and 3.1-B of California’s State Plan.³⁸

If state or federal law adds or changes a benefit, Medi-Cal would either need to cover the benefit or list an actuarially equivalent benefit.³⁹ In that case, the Department of Health Care Services would submit a State Plan Amendment to draw down federal funding for providing these services to beneficiaries.⁴⁰

It is important to note that while Medi-Cal is also required to cover the 10 EHB categories, the specific benefits included in the chosen Medi-Cal benchmark plan may be different from the specific benefits included in the commercial benchmark plan because the EHB benchmark plan is different from the ABP in California.

³⁴ 42 U.S.C. §1396u-7.

³⁵ Like the State Plan, the ABP is a contract between the Department of Health Care Services and the Center for Medicare and Medicaid Services for Title XIX funding for Medicaid Services.

³⁶ Alternative Benefit Plan Final Rule. *Federal Register*, Vol. 78, No. 135. July 14, 2013. Available at: <https://www.govinfo.gov/content/pkg/FR-2013-07-15/pdf/2013-16271.pdf>.

³⁷ 42 U.S.C. §1396u-7, as described by the Alternative Benefit Plan Final Rule, cited above.

³⁸ California’s state plan can be found online at: <https://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx>. This is also consistent with WIC § 14132.02.

³⁹ As required by 42 U.S.C. §18022(d).

⁴⁰ Communication between CHBRP and the Department of Health Care Services. October 14, 2019.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report. Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications are available at <http://www.chbrp.org>.

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CHBRP assumes full responsibility for the issue brief and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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