



ASPE

ISSUE BRIEF

ESSENTIAL HEALTH BENEFITS: INDIVIDUAL MARKET COVERAGE

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- **The Affordable Care Act identified ten categories of services and items included in essential health benefits (EHBs).** The ten categories include: 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; and pediatric services, including oral and vision care.
- **All ten categories of services and items must be covered by insurance offered in the individual and small group markets as of January 1, 2014.¹**
- **According to data on currently marketed plans submitted by health insurance companies to HealthCare.gov, many individuals and families who purchase their own health insurance do not currently have coverage for several of the categories of benefits included in EHBs.²**
 - 62 percent of enrollees do not have coverage for maternity services.
 - 34 percent of enrollees do not have coverage for substance abuse services.
 - 18 percent of enrollees do not have coverage for mental health services.
 - 9 percent of enrollees do not have coverage for prescription drugs.
- **Americans who buy coverage in the individual market in 2014 will gain access to essential health benefits.** Based on current estimates of the size of the individual market³ and the percent of enrollees in currently marketed plans without coverage for certain services, coverage of benefits in the individual market may expand as follows:⁴
 - 8.7 million Americans will gain maternity coverage.
 - 4.8 million Americans will gain substance abuse coverage at parity with medical and surgical benefits.
 - 2.3 million Americans will gain mental health coverage at parity with medical and surgical benefits.
 - 1.3 million Americans will gain prescription drug coverage.

¹ EHBs apply to non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs.

² Data were submitted by health insurance issuers in to HealthCare.gov in June 2011, including coverage of benefits in individual market plans and total enrollment in each individual market plan. These plans cover about 4 million people – there are another 10 million people enrolled in plans that are not open or did not submit data to HealthCare.gov. Data is only required to be submitted for plans currently accepting new enrollees that account for more than 1 percent of an issuer’s enrollment in a given zip code, and these numbers only reflect plans that were successfully presented on HealthCare.gov in June 2011. If the benefits covered in these open plans are similar to those covered in closed or grandfathered plans, then these numbers can be extrapolated to the individual market.

³ The total number of individuals was calculated by multiplying the proportion of individuals without coverage from HealthCare.gov with America’s Health Insurance Plans estimate of 14 million enrollees in the individual market (See <http://www.ahip.org/Issues/Individual-Market-Health-Insurance.aspx>).

⁴ These numbers do not include estimates of small group market enrollees whose coverage does not currently include these benefits. Some small group market plans sell riders for benefits such as maternity, mental health, substance abuse, and prescription drugs. Individual companies can decide whether or not to purchase any available riders for these benefits.