**Essential Health Benefits Requirements**

**Summary:** Defines an essential health benefits package that (1) covers essential health benefits, (2) limits cost-sharing, and (3) has a specified actuarial value (pays for a specified percentage of costs). Requires the Secretary to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan. For all plans in all markets, prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts. For the small group market, prohibits deductibles that are greater than $2,000 for individuals and $4,000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums. Also requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs: Bronze -- 60 percent, Silver -- 70 percent, Gold -- 80 percent, and Platinum -- 90 percent. In the individual market, a *catastrophic plan* may be offered to individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they have a hardship. A catastrophic plan must cover essential health benefits and at least 3 primary care visits, but must require cost-sharing up to the HSA out-of-pocket limits. Also, if an insurer offers a qualified health plan, it must offer a *child-only plan* at the same level of coverage. Finally, it includes specific payment requirements for Federally Qualified Health Centers (FQHC).

**Status Updates:**
- On August 4, 2011, the National Health Council released an actuarial assessment of health insurance coverage.
- On August 29, 2011, the Institute of Medicine (IoM) released a report detailing the discussion regarding this topic, with the recommendations due out this Fall.

**Timeline:**
- November 4, 2010 – IoM announces a consensus study regarding the determination of essential health benefits.
- December 6, 2010 – Comments due to the IoM regarding essential health benefits.
- January 12-14, 2011 – First meeting of the IoM Committee on the Determination of Essential Health Benefits. The first day, January 12, will be closed to the public to observe committee proceedings. On January 13-14, there will be some open sessions.
- March 21, 2011 – Third meeting with no public sessions.
- April 15, 2011 -- Secretary of Labor submitted a report to the Secretary of Health and Human Services entitled, “Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services.”
- May 26, 2011 -- Milliman issued a client report on behalf of Pfizer related to “typical” health care plan standard, with an emphasis on prescription drug benefits.
• August 29, 2011 – IoM released its report detailing the discussions regarding this topic.
• September 2011 – Expected completion of the IoM study regarding essential benefits.

**Additional information:**

• August 29, 2011 IoM report (no recommendations) --

• August 4, 2011 National Health Council actuarial report –
  [http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_Avalere_1ppt.pdf](http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_Avalere_1ppt.pdf)


• Secretary of Labor report to the Secretary of Health and Human Services --

• IoM announcement of the second public meeting (including registration information) –

• IoM announcement of first public meeting (including registration information) --

• IoM announcement regarding consensus study (with link to comment form on page) --

• Healthcare.gov information regarding essential health benefits --
  [http://www.healthcare.gov/glossary/e/essential.html](http://www.healthcare.gov/glossary/e/essential.html)

**Long summary:**

**Definition of essential benefit package.** Defines the Essential Benefit package as coverage that:

1. provides for the essential health benefits;
2. limits cost-sharing; and
3. provides either the bronze, silver, gold, or platinum level of coverage.

**Essential health benefits.** The Secretary of Health and Human Services (Secretary) must define the essential health benefits, except that the benefits must include at least the following general categories and items and services covered within the categories: 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. In defining the benefits, (1) the Secretary must provide notice and an opportunity for public comment on initial definition and
any revisions and (2) must ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary and as certified by the Chief Actuary of CMS (and reported to the appropriate committees of Congress). To determine the scope of the typical employer plan, the Secretary of Labor must conduct a survey of employer-sponsored coverage, including multiemployer plans, and report such survey to the Secretary of Health and Human Services. In addition, the Secretary must

(1) ensure that the essential health benefits reflect an appropriate balance among the categories so that benefits are not unduly weighted toward any category;

(2) not make 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;

(3) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(4) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(5) provide that a qualified health plan not be treated as providing coverage for the essential health benefits unless the plan provides that: (a) coverage for emergency department services will be provided without imposing any requirement for prior authorization of services or any limitation on coverage where the provider does not have a contractual relationship with the plan for services that is more restrictive than the requirements or limitations that apply to emergency department services received from contracting providers; and (b) if such services are provided out-of-network, the cost-sharing requirement is the requirement that would apply if such services were provided in-network;

(6) provide that if a stand-alone dental benefits plans is offered through an Exchange, another health plan offered through the Exchange will not fail to be treated as a qualified health plan solely because it does not offer coverage of benefits offered through the stand-alone plan that are otherwise required for pediatric services (including oral and vision care);

(7) periodically review the essential health benefits and provide a report to Congress and the public that contains: an assessment of access to the benefits and whether they need to be modified or updated to account for changes in medical evidence or scientific advancement; information on any modifications to address gaps in access or changes in the evidence base; an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described above. The Secretary is to periodically update the essential health benefits to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in this review.

Note: Nothing in this title prohibits a health plan from providing benefits in excess of the essential health benefits.

Cost-sharing. Limits cost-sharing incurred under a health plan for a plan year beginning in 2014 to the dollar amounts in effect for HSA-qualified high deductible health plans for self-only and family coverage, respectively.\(^1\) For 2015 and later, the limitation in the case of self-only coverage will be the above dollar amount for self-only coverage increased by the product of that amount and the premium adjustment percentage for the calendar year (i.e., the percentage (if any) by which the average per capita premium for coverage in the U.S. for the preceding year exceeds the 2013 average per capita premium); and in the case of non self-only coverage, twice this amount.

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\(^1\)In 2010, the maximum out-of-pocket limit is $5,950 for an individual; family coverage, $11,900. These amounts are indexed annually for inflation.

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In the case of a health plan offered in the small group market, the deductible under the plan not exceed $2,000 for a single individual; and $4,000 in the case of any other plan. Permits these amounts to be increased by the maximum amount of reimbursement reasonably available to a participant under a flexible spending arrangement (determined without regard to any salary reduction arrangement). Provides for indexing of these amounts to the product of the amounts and the premium adjustment percentage for the calendar year. Applies this limitation so as to not affect the actuarial value of any plan, including a plan in the bronze level. Clarifies that this does not permit a plan to require a deductible for preventive benefits (see §2713 above).

Cost-sharing includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of §223(d)(2)) of the IRC with respect to essential health benefits covered under the plan. Does not include premiums, balance billing amounts for non-network providers, and spending for non-covered services.

**Levels of coverage.** The bronze plan must provide a level of coverage designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan. The silver plan must provide 70%; the gold plan 80%; and the platinum plan 90%. Requires under regulations issued by the Secretary that the level of coverage of a plan be determined on the basis that the essential health benefits be provided to a standard population (and without regard to the population for which the plan may actually provide benefits). Secretary must (1) issue regulations under which employer contributions to an HSA may be taken into account in determining the level of coverage for a plan of the employer and (2) develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

**Catastrophic plan.** Provides that if a health plan does not provide a bronze, silver, gold, or platinum level of coverage, it shall be treated as qualified for any plan year if: (1) the only individuals who are eligible to enroll in the plan are individuals under the age of 30 before the beginning of the plan year or those with a certification in effect for that year that the individual is exempt from the individual responsibility requirement because other coverage is not affordable or because of the hardship exemption (see “Individual mandate” below); (2) the plan provides the essential health benefits except that it provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation (but not for preventive services) described above for the plan year; and provides coverage for at least three primary care visits; and (3) it is only offered in the individual market.

**Child-only plans.** Provides that if a qualified health plan is offered through a state Exchange for any level of coverage (i.e., bronze, silver, gold or platinum), the issuer is required to also offer a plan through the Exchange at that level in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

**Payments to Federally Qualified Health Centers (FQHCs).** Provides that if any item or service covered by a qualified health plan is provided by a FQHC, the offeror of the plan is required to pay the FQHC at least the Medicaid reimbursement amount.

**Effective date.** The effective date is March 23, 2010 (date of enactment).
Legislative text:
SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.
(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—
(1) provides for the essential health benefits defined by the Secretary under subsection (b);
(2) limits cost-sharing for such coverage in accordance with subsection (c); and
(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in sub- section (d).
(b) ESSENTIAL HEALTH BENEFITS.—
(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:
(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.
(2) LIMITATION.—
(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multimemployer plans, and provide a report on such survey to the Secretary.
(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).
(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.
(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—
(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;
(B) not make 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;
(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life;
(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—
(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and
(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;
(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J), and (G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—
(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;
(ii) an assessment of whether the essential health benefits need to be modified or updated to account for changes in medical evidence or scientific advancement;
(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;
(iv) an assessment of the potential of additional or expanded benefits to increase costs and the inter- actions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and
(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).
(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.
(c) REQUIREMENTS RELATING TO COST-SHARING.—
(1) ANNUAL LIMITATION ON COST-SHARING.—
(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue
(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-
subsection (c)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.
(ii) deductibles, coinsurance, copayments, or similar charges; and
(A) IN GENERAL.—The term “cost-sharing” includes—
(ii) $4,000 in the case of any other plan. The amounts under clauses (i) and (ii) may be increased by the maximum amount of
reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of
the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).
(B) INDEXING OF LIMITS.—In the case of any plan year beginning in a calendar year after 2014—
(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium
adjustment percentage under paragraph (4) for the calendar year; and
(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to the amount in effect under subparagraph
(A)(i) for plan years beginning in the calendar year, determined after application of clause (i). If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.
(C) ACTUARIAL VALUE.—The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of
any health plan, including a plan in the bronze level.
(D) COORDINATION WITH PREVENTIVE LIMITS.—Nothing in this paragraph shall be construed to allow a plan to have a deductible
under the plan apply to benefits described in section 2713 of the Public Health Service Act.
(3) COST-SHARING.—In this title—
(A) IN GENERAL.—The term “cost-sharing” includes—
(i) deductibles, coinsurance, copayments, or similar charges; and
(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section
223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.
(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are
equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.
(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially
equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.
(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially
equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.
(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are
actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.
(2) ACTUARIAL VALUE.—
(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the
essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the
plan may actually provide benefits to).
(B) EMPLOYER CONTRIBUTIONS.—The Secretary shall issue regulations under which employer contributions to a health savings
account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of
coverage for a plan of the employer.
(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of
the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or
coverage, the rules contained in the regulations under this paragraph shall apply.
(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations
used in determining the level of coverage of a plan to account for differences in actuarial estimates.
(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified
health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.
(c) CATASTROPHIC PLAN.—
(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the
requirements of subsection (d) with respect to any plan year if—
(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and
(B) the plan provides—
(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no
benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect
under subsection (c)(1) for the plan year (except as provided for in section 2713); and
(ii) coverage for at least three primary care visits.
(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—
(A) has not attained the age of 30 before the beginning of the plan year; or
(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) PAYMENTS TO FEDERALEY-QUALIFIED HEALTHCENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.