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Comprehensive Health Coverage—Essential Health Benefits Package

The Affordable Care Act (ACA) requires non-grandfathered health insurance plans in the individual and small group markets to offer comprehensive health coverage, known as the **essential health benefits package**. This requirement is effective for **plan years beginning on or after Jan. 1, 2014**.

Under the essential health benefits package, a health insurance plan is required to:

- Cover a core set of items and services, known as essential health benefits;
- Limit cost-sharing for essential health benefits; and
- Provide either a bronze, silver, gold or platinum level of coverage (or a catastrophic plan in the individual market).

AFFECTED HEALTH PLANS

The essential health benefits package requirement applies to non-grandfathered insured health plans in the **individual and small group markets, both inside and outside of the health insurance Exchanges**. Thus, group health plans purchased by small employers outside of the Exchange's Small Business Health Options Program (SHOP) must provide the essential health benefits package.

This comprehensive coverage requirement does NOT apply to:

- Grandfathered health plans;
- Self-insured group health plans; and
- Health insurance plans offered in the large group market.

However, as explained below, the out-of-pocket maximum for essential health benefits applies to all non-grandfathered plans, including self-insured group health plans and insured health plans of any size.

Small Group Market

To make health insurance coverage for small groups more affordable and to apply additional consumer protections, the ACA expands the small group market. Under the ACA, a "small employer" is an employer that employed an average of at least one employee, but not more than **100 employees,** on business days during the preceding calendar year, and also that employs at least one employee on the first day of the plan year.

An employer not in existence during the preceding calendar year must determine whether it is a small or large employer based on the average number of employees that it reasonably expects to employ on business days in the current calendar year. Also, the tax code's aggregation rules for controlled groups, companies under common control and affiliated service groups apply when determining an employer's size.

Also, for **plan years beginning before Jan. 1, 2016**, a state may elect to define "small employer" as an employer that employed an average of at least one employee, but not more than **50 employees,** on business days during the

preceding calendar year. Thus, states have the option to delay the ACA's expansion of the small group market until Jan. 1, 2016. Most states have defined a small employer as one with 50 or fewer employees.

The Department of Health and Human Services (HHS) has indicated that it intends to issue guidance in the future about how to count employees in order to determine the market size of a group health plan. Currently, states use a variety of different methods to calculate employer group size.

Optional Transition Policy

In November 2013, HHS created a transition policy that allows issuers in the individual and small group markets to renew health insurance policies that do not comply with certain ACA reforms that are effective for 2014, including the essential health benefits requirement. Originally, HHS announced that the transition policy would last one year; however, HHS later extended the transition policy for two additional years, to **policy years beginning on or before Oct. 1, 2016**.

Due to this transition policy, some insured group health plans for small employers may not include the essential health benefits package. If an issuer is using the transition relief, it is required to send a **notice** to the employer that explains which ACA reforms are not included in the health plan's coverage.

The transition policy is not available in every state. Because the insurance market is primarily regulated at the state level, state governors or insurance commissioners must allow issuers in their states to use the transition policy. Also, even if the transition policy is available in a state, health insurance issuers are not required to follow the transition relief and renew plans that do not comply with ACA reforms.

In addition, transition relief also applies to **large employers** that currently purchase insurance in the large group market, but that as of Jan. 1, 2016, will be redefined by the ACA as small employers purchasing insurance in the small group market. At the option of the states and health insurance issuers, these large employers may renew their current policies through policy years beginning on or before Oct. 1, 2016, without their policies being considered as out of compliance with the specified ACA reforms that apply to the small group market but not to the large group market, such as the essential health benefits package requirement.

ESSENTIAL HEALTH BENEFITS

Effective for plan years beginning on or after Jan. 1, 2014, insured health plans in the individual and small group markets must cover a core set of items and services, known as essential health benefits.

The ACA requires essential health benefits to reflect the scope of benefits covered by a typical employer and to cover at least the following **10 general categories** of items and services:

- Ambulatory patient services (outpatient care)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder benefits, 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

EM 9/14

Comprehensive Health Coverage—Essential Health Benefits Package

The ACA directed HHS to more specifically define the items and services that comprise essential health benefits. HHS developed a state-specific **benchmark approach** for defining essential health benefits. Under this approach, each state selected a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state. If a state did not select a benchmark plan, HHS selected the small group plan with the largest enrollment in the state as the state's default benchmark plan.

As a general rule, the items and services included in a state's benchmark plan comprise the essential health benefits that insured health plans in the state's individual and small group markets must cover.

More information on the benchmark plans, including the benchmark plan for each state, is available on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

COST-SHARING LIMITS

Effective for plan years beginning on or after Jan. 1, 2014, the ACA requires non-grandfathered health plans to comply with cost-sharing limits with respect to their coverage of essential health benefits. Cost sharing includes any expenditure required by or on behalf of an enrollee with respect to essential health benefits, such as deductibles, copayments, coinsurance and similar charges.

As enacted, the ACA's cost-sharing limits included an overall annual limit (or out-of-pocket maximum) and an annual deductible limit. However, on April 4, 2014, the ACA's annual deductible limit was **repealed**, effective as of the date of the ACA's enactment. The repeal did not affect the out-of-pocket maximum.

Out-of-pocket Maximum

The out-of-pocket maximum for essential health benefits applies to **all non-grandfathered plans**. This includes, for example, self-insured health plans and insured health plans of any size. Thus, even plans that are not required to cover essential health benefits (for example, insured plans for large employers) must comply with the ACA's out-of-pocket maximum for any covered benefits that fall within the scope of essential health benefits.

The out-of-pocket maximum limits for 2014 and 2015 are as follows:

2014	$6,350 for self-only coverage and $12,700 for family coverage
2015	$6,600 for self-only coverage and $13,200 for family coverage

Once the out-of-pocket maximum is reached for the year, the enrollee is not responsible for additional cost sharing for essential health benefits for the remainder of the year.

Other Limits

Effective for plan years beginning on or after Sept. 23, 2010, the ACA prohibits all health plans from placing **lifetime dollar limits** on essential health benefits.

In addition, effective for plan years beginning on or after Jan. 1, 2014, all health plans are prohibited from placing **annual dollar limits** on essential health benefits. Prior to 2014 plan years, restricted annual limits on essential health benefits were permitted. For example, unless a plan received a waiver of the restricted annual limits, its annual limit on essential health benefits for the 2013 plan year could not be less than $2 million.

In order to determine which benefits are essential health benefits for the purpose of removing annual and lifetime dollar limits, a self-insured group health plan, large group market health plan, or grandfathered group health plan may choose **any benchmark plan from any state** that was approved by HHS. (Frequently Asked Question ID 1364).

EM 9/14

METAL LEVELS OF COVERAGE

To satisfy the requirement to offer the essential health benefits package, issuers in the individual and small group markets (both inside and outside of the Exchanges) must provide a level of coverage that meets certain actuarial values. The ACA's required actuarial values are referred to as "**metal levels"—bronze, silver, gold and platinum**.

Alternatively, issuers in the individual market may offer a catastrophic plan for young adults and persons who are exempt from the individual mandate because affordable coverage is unavailable or they have a hardship exemption.

Actuarial value is calculated as the percentage of total average costs for essential health benefits that a plan will cover. A health plan's actuarial value tells consumers how generous the plan's coverage is based on its cost-sharing provisions (that is, deductibles, copayments and coinsurance). Plans with higher actuarial values provide coverage that is more generous. For example, if a plan has an actuarial value of 70 percent, on average, a consumer would be responsible for 30 percent of the costs of covered benefits. If a plan has an actuarial value of 80 percent, on average, a consumer would be responsible for 20 percent of the cost of covered benefits.

Each metal level is based on a specified share of the actuarial value of the plan's essential health benefits. Bronze plans have the least generous coverage, while platinum plans have the most generous coverage. Coverage levels are as follows:

Bronze Level	Silver Level	Gold Level	Platinum Level
60 percent actuarial value	70 percent actuarial value	80 percent actuarial value	90 percent actuarial value

In the small group market, special standards for determining actuarial value apply to high deductible health plans (HDHPs) offered with health savings accounts (HSAs) and health plans integrated with health reimbursement arrangements (HRAs).

EM 9/14