For plan years beginning on or after Jan. 1, 2014, all non-grandfathered fully insured health plans offered in the individual and small group markets, whether on or off an exchange, will be required to:

1. Cover essential health benefits that include items and services in 10 categories
2. Provide essential health benefits coverage that is substantially equal to a state’s essential-health-benefits benchmark plan;
3. Adhere to specific cost-sharing limits (some of these limits also apply to large group and self-funded plans); and
4. Meet specific actuarial values, commonly referred to as “metal levels.”

**Categories of essential health benefits**

For plan years beginning on or after Jan. 1, 2014, all non-grandfathered fully insured health plans offered in the individual and small groups will be required to offer essential health benefits in the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn services
5. Mental health and substance abuse services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

**States mandated to select benchmark plan**

By regulation, every state must have an essential-health-benefits benchmark plan. Each state has the option to select an essential-health-benefits benchmark plan from the following four choices:

1. Any of the three largest small group insurance products in the state by enrollment
2. Any of the three largest employee health plan options available to state employees
3. Any of the three largest national Federal Employee Health Benefit Program plan options by aggregate enrollment
4. The largest non-Medicaid HMO in the state by enrollment

If the state does not select an essential-health-benefits benchmark plan, the default essential-health-benefits benchmark plan will be the largest plan by enrollment in the state’s small group market.

If the essential-health-benefits benchmark plan selected does not provide coverage in each of the 10 categories, it must be supplemented to include the missing category.

If the essential-health-benefits benchmark plan lacks pediatric oral or pediatric vision services, it may be supplemented by adding the pediatric oral and pediatric vision benefits available under the state’s Children’s Health Insurance Program, if one exists, or the pediatric oral benefits under the federal employee dental and vision plan with the largest national enrollment (FEDVIP)\(^1\).

Special rules apply to qualified health plans offered on an exchange where standalone dental coverage is sold or when medical coverage is sold outside of the exchange to someone who purchased standalone coverage on the exchange.

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If the essential-health-benefits benchmark plan does not include coverage for habilitative services (a term that has not been defined by federal regulation), then the state may determine which services are included in that category. See further discussion of habilitative services below.

### Providing coverage that is ‘substantially equal’ to a state’s benchmark plan

Non-grandfathered insurance plans offered in the individual and small group insurance market must provide benefits that are substantially equal to the essential-health-benefits benchmark plan including covered benefits, limitations on coverage including coverage of benefit amount, duration and scope, and prescription benefits that cover at least the greater of: (i) one drug in every U.S. pharmacopeia category or class or (ii) the same number of prescription drugs in each category and class as the essential-health-benefits benchmark plan. The plan must submit its drug list to the exchange, the state or the federal Office of Personnel Management, depending on the plan at issue. The plan must have a process for allowing an enrollee to request clinically appropriate drugs not covered by the plan.

With respect to mental health and substance use disorders, the rule extends the federal parity requirements that currently apply only to the large group market to the essential-health-benefits plans offered in individual and small group markets.

If the essential-health-benefits benchmark plan does not include habilitative services, and the state chooses not to determine which services fall into this category, then the carrier may either provide habilitative services in parity with rehabilitative services that are similar in scope, amount and duration, or the carrier may determine what habilitative services it will provide and report this to HHS.

Benefit substitution is allowed only if the substitute benefit is actuarially equivalent to the benefit that is being replaced, is made within the same essential health benefit category, and is not a prescription drug benefit. Actuarial equivalence of benefits is determined regardless of cost-sharing. The carrier must submit evidence of actuarial equivalence of the substituted benefit to the state. The certification must be:

- Conducted by a member of the American Academy of Actuaries (AAA),
- Be based on an analysis performed in accordance with generally accepted actuarial principles and methodologies, and
- Use a standardized plan population.

An issuer may not include routine non-pediatric dental or vision services, long-term/custodial care or cosmetic orthodontia as essential health benefits.

### Cost-Sharing Limits

For plan year beginning on or after Jan. 1, 2014, cost sharing may not exceed the amounts applicable to qualified high deductible health plans as set forth in Internal Revenue Code sections 223(c)(2)(A)(ii)(I) for self-only coverage and (II) for family coverage. This amount will be adjusted annually.

These maximums apply to all group health plans, whether fully insured or self funded, whether small group or large group. The cost-sharing maximum amount includes deductibles, coinsurance, co-payments and other similar amounts, but not premiums. For 2013, the maximums are $6,250 for self-only coverage and $12,500 for family coverage. Until the first renewal date in 2015, plans using other service providers (such as a separate pharmacy benefit manager) may keep the out-of-pocket expenses for such coverage separate, as long as neither out-of-pocket amount separately exceeds the maximum allowed.

For fully insured health plans in the small group insurance market, the annual deductible may not exceed $2,000 for self-only coverage and $4,000 for family coverage. This amount will be adjusted annually. The deductible limit may be exceeded if the plan may not reasonably reach the actuarial value of a given metal tier without exceeding the deductible limit.

For network plans, out-of-network cost-sharing and deductibles may remain separate.
Actuarial value and minimum value

Actuarial value

Fully insured health plans must meet actuarial values identified in the rule. In most instances, issuers must use the actuarial-value calculator provided by HHS to calculate the actuarial value of a health plan. If the health plan's design is not compatible with the actuarial-value calculator, the issuer must:

a) Calculate the plan's actuarial value by estimating a fit of its plan design into the parameters of the actuarial-value calculator and having an AAA actuary certify that the plan design was fit appropriately; or

b) Use the actuarial-value calculator to determine the actuarial value for the plan provisions that do fit in the calculator parameters and have a AAA actuary calculate appropriate adjustments to the actuarial value identified by the calculator for plan design features that deviate substantially from the parameters of the actuarial value calculator and

c) Submit the actuarial certification on the chosen methodology. These calculation methods may include only in-network cost-sharing, including multi-tier networks.

Annual employer contributions to health savings accounts (HSAs) and amounts newly made available under health reimbursement arrangements (HRAs) for the current year in the small group market are:

• Counted toward the total anticipated medical spending of the standard population that is paid by the health plan; and

• Adjusted to reflect the expected spending for health care costs in a benefit year so that any current year HSA contributions are accounted for, and the amounts newly made available under an HRA for the current year are accounted for.

Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set will be used as the standard population to calculate actuarial value. Otherwise, actuarial value will be calculated using the default standard population set by HHS.

Levels of coverage: metal levels

The metal levels determined by the actuarial-value calculator or other safe harbors are:

• Bronze = 60 percent actuarial value
• Silver = 70 actuarial value
• Gold = 80 percent actuarial value
• Platinum = 90 actuarial value

Health plans are allowed a deviation from the actuarial value of plus or minus 2 percentage points.

Minimum value

Employers with 50 or more full-time employees and equivalents will also need to determine if their plan provides minimum value as this concept relates to the potential penalties to which an employer may be subject under PPACA's shared responsibility proposed rule. An employer-sponsored plan provides minimum value if the percentage of the total allowed costs of benefits provided under the plan is no less than 60 percent.

For purposes of determining if an employer-sponsored plan provides minimum value, the plan may use the following methods:

1. The minimum-value calculator from HHS
2. Any safe harbor established by HHS and the IRS. (At the time this document was published, federal agencies had not yet established any safe harbors.)
3. Certification by an AAA actuary to determine minimum value if neither option above is appropriate.

In the event that a group health plan uses the minimum-value calculator and offers essential health benefits outside of the parameters of the minimum-value calculator, the plan may seek an AAA actuary to determine the value of that benefit and adjust the result derived from the minimum-value calculator to reflect that value.

A group health plan will be permitted to take into account all benefits provided by the plan that are included in any of the essential-health-benefits benchmarks plans.

The standard population that HHS applied to develop the minimum value calculator reflects the population covered by large group health plans, including self-funded plans.
List of essential-health-benefits benchmark plans
More information about each state’s benchmark plan is available at: http://cciio.cms.gov/resources/data/ehb.html