ACA Essential Health Benefits

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This practice note explains the rules related to essential health benefits (EHB) under the Patient Protection and Affordable Care Act (*Pub. L. No. 111-148*), as amended by the Health Care and Education Reconciliation Act (*Pub. L. No. 111-152*) (ACA). EHB are specific health plan benefits, as designated by each state under ACA rules, that represent a package of comprehensive insurance coverage that certain health plans must provide, including qualified health plans (QHPs) offered on an ACA exchange and all small group plans and individual policies offered by insurers. Large group plans and self-insured plans are generally exempt from mandatory coverage of EHB. However, an EHB analysis is also important for the broader range of plans that are subject to the ACA's cost sharing rules and to calculate a plan's actuarial value of benefits and metal rating (bronze, silver, gold, or platinum). Benefits practitioners need to be familiar with these rules to advise their clients on compliance and cost analysis of their healthcare benefit offerings.

This practice note is organized in the following sections:

- *Essential Health Benefits Rules*
- *EHB Mandatory Coverage Requirement*
- *Cost Sharing Rules and Benefit Limit Restrictions for EHB*
- *Actuarial Value and Metal Categories*

Essential Health Benefits Rules

The ACA rules that relate to EHB include the following, each of which is described further later in this practice note:

- Insured small group plans and individual policies must cover EHB at the applicable level of coverage for the state. Public Health Service Act (PHSA) § 2707 (*42 U.S.C. § 300gg-6(a)*).
- Qualified health plans (QHPs), including multistate plans, must cover all EHB at the specified level of coverage for the state. *42 U.S.C. § 18021(a)(1)(B)*.
- Cost sharing limits and annual limits apply for any EHB offered under any plan (whether subject to mandatory coverage for the plans above or voluntarily provided by the plan). Thus, for example, self-funded employer plans need to identify which of its benefits are categorized as an EHB to ensure compliance with those rules (unless it imposes no cost sharing and has no dollar coverage limits). *42 U.S.C. § 18022(c)*; PHSA § 2711 (*42 U.S.C. § 300gg-11*).
- The actuarial value of a plan is a measure of the proportion of the cost for EHB that is covered by the plan versus that borne by a participant through cost sharing. The resulting percentage determines the metal category of the plan (bronze, silver, gold, or platinum). *42 U.S.C. § 18022(d)*.

EHB should be distinguished from minimum essential coverage (MEC), a separate ACA term associated with the Act's individual mandate to obtain health coverage or pay a tax (penalty eliminated for plan years beginning in 2019) and employer shared responsibility rules that impose an excise tax on employers for not offering MEC

coverage to full-time employees under *I.R.C. § 4980H(a)*. Whereas EHB set a base level of specific benefits that certain plans must provide, MEC refers more generally to certain plan types that satisfy the coverage requirement to avoid those tax penalties. *I.R.C. § 5000A(f)(1)*; *Treas. Reg. § 1.5000A-2*.

EHB Categories and Establishing Scope of Coverage

The ACA requires the EHB package to include health-care benefits in 10 categories, along with any other benefits designated by the responsible agency, the Department of Health and Human Services (HHS). The EHB are to be provided at a level that is consistent with the scope of a "typical" employer-sponsored health plan and provide an appropriate balance across the enumerated categories. *42 U.S.C. §§ 18022(a)*, *(b)*.

The 10 statutory categories are:

- Ambulatory patient services (outpatient care)
- Emergency services (with special rules prohibiting QHPs from imposing prior authorization requirements or higher cost sharing for out-of-network services)
- Hospitalization (inpatient care)
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment (for most employer-provided plans, benefits in this category implicate the parity rules discussed in *Mental Health Parity and Addiction Equity Act Compliance for Employer Health Plans*).
- 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

42 U.S.C. § 18022(b).

States' Role in Establishing EHB

To fulfill its obligation to establish and periodically review and update EHB, HHS adopted a benchmarking framework allowing each state to set a tailored EHB package for its jurisdiction. Under this approach, each state could select from any of the following 10 base plans as a basis for their benchmark plan:

- Any of the three largest small group product plans in the state
- Any of the three largest state-employee plans in the state
- Any of the three largest Federal Employees Health Benefits Program (FEHBP) plan options
- The plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization (HMO) in the state.

45 C.F.R. § 156.100.

Then, where required, the state would need to enhance the selected base plan if it failed to cover benefits in any of the mandatory 10 EHB categories. The scope of benefit coverage for EHB under the selected benchmark plan, as supplemented (i.e., the scope of coverage, limitations on amount, duration, and scope, and prescription drug benefits) is then used to gauge EHB compliance within that state under the ACA. *45 C.F.R. §§ 156.100*, *156.110*, *156.115*.

The benchmark plan EHB (and all plans subject to the EHB mandate) must also meet nondiscrimination standards, precluding discrimination in coverage, reimbursement rates, incentive programs, or other benefits based on age, disability, or expected length of life. *42 U.S.C. § 18022(b)(4)(B)*, *(D)*; *45 C.F.R. 156.125*.

Benefit Substitution

Under rules being phased out, the EHB benchmark plan sets a floor on the scope of benefits that must be offered within each category. For example, if the benchmark plan provides for 60 days of skilled nursing for an EHB, the plan must at least match that, or provide an equivalently valuable substitute benefit within the same category. That is, a plan or policy may be permitted to provide a diminished scope of benefits under an EHB category (other than for prescription drugs) compared to the benchmark plan if it substitutes a benefit within that category so that the EHB has an equivalent (or higher) actuarial value. Certification by an actuary is required to make such substitutions. *45 C.F.R. § 156.115(b)* (as promulgated under *78 Fed. Reg. 12,834, 12,867 (Feb. 25, 2013)*. Under recent changes, first effective for the 2020 plan year (described in the next paragraph), issuers may be able to substitute benefits across EHB categories as well.

New Rules for 2020 Plan Years and Later

The benchmarking rules have been loosened for plan years beginning on or after January 1, 2020. *83 Fed. Reg. 16,930, 17,009 (April , 2018)*. Under the new rules:

- States will have three additional EHB benchmark plan options: (1) selecting another state's 2017 benchmark plan, (2) substituting the benefits within another state's 2017 benchmark plan for one or more EHB categories in its own 2017 benchmark plan, or (3) designing a benchmark plan from scratch. *45 C.F.R. 156.111(a)*.
- In all cases, a state's benchmark plan must:
    - o Provide a scope of benefits within each category at least equal in actuarial value as compared to a typical employer plan, newly defined as either (1) any of the 10 EHB benchmark plans under the old rules or (2) the largest plan within one of the five largest insurance products in the state, provided that such plan meets certain requirements (e.g., a size threshold and satisfaction of ACA's minimum value standard) – and–
    - o Not be more generous than the most-generous benchmark plan option.

    45 C.F.R. 156.111(b) (see also *HHS, Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-Benchmark Plan*).
- States may choose to allow insurers to substitute benefits across EHB categories, not just within categories. That is, a plan or policy could omit a benefit from the state's EHB benchmark plan in one category if it substitutes a benefit of at least equivalent actuarial value in another category. *45 C.F.R. § 156.115(b)*.

EHBs and Novel Coronavirus

The spread of novel coronavirus (COVID-19) prompted HHS's Centers for Medicare & Medicaid Services (CMS) to issue information clarifying federal rules governing health insurance coverage, including the EHB rules, in connection with viral infections. See *CMS, Information Related to COVID-19 Individual and Small Group Market Insurance Coverage*.

EHB Mandatory Coverage Requirement

The following types of plans and coverage are subject to the mandatory coverage of EHB:

- **Non-grandfathered small group market plans and individual policies offered by an insurer.**

o A small group market plan is an insured plan offered on the health insurance market that is maintained by a small employer (i.e., having on average 100 or fewer employees). *42 U.S.C. §300gg-91(e)*.

o The grandfathered plan exception has decreasing relevance as there are ever fewer plans that have not been material modification since March 23, 2010. See *ACA Grandfathered Plan Rules*.

42 U.S.C. § 300gg-6(a)

- **QHPs.** Only QHPs are eligible to be offered on an ACA exchange. Coverage of EHBs by plans and policies offered by certified issuers are the key features of QHPs. *42 U.S.C. § 18021(a)(1)*.
- **Multistate plans.** These are ACA exchange plans procured by the federal government through private insurers. *42 U.S.C. § 18054(c)(1)(A)*.
- **Alternative benefit plans (Medicaid benchmark and benchmark-equivalent plans).** These Medicaid-alternative plans must cover the 10 EHB categories, but are not subject to all EHB rules. *42 U.S.C. § 1396u-7(b)(5)*; *42 C.F.R. § 440.347(a)*.
- **Basic health programs.** These programs for certain low-income individuals must cover the 10 EHB categories, but are not subject to all EHB rules. *42 U.S.C. § 18051(a)(1)*.

The following plans are not subject to the EHB coverage mandate:

- Self-funded employer plans and other self-insured arrangements
- Large group market plans (insured plans for employers having over 100 employees on average)
- Grandfathered plans and policies
- Excepted benefits (e.g., certain stand-alone dental and vision benefits, certain employee assistance programs, long-term care insurance, and certain supplemental insurance); for more information, see *ACA and HIPAA Excepted Benefits*.

Despite being excluded from the coverage mandate, the non-grandfathered group health plans in the list are subject to the EHB (and preventive services) cost sharing limitations discussed in the next section if they offer EHB. Thus, they generally need to identify any EHB for compliance.

Cost Sharing Rules and Benefit Limit Restrictions for EHB

The following summarizes cost sharing rules and benefit limitations related to EHB provided under group health plans.

EHB Cost Sharing Rules

Any non-grandfathered group health plan's EHB package must be designed not to exceed the ACA cost sharing limits. See *42 U.S.C. §§ 300gg-11*, *18022(c)*; *45 C.F.R. § 156.130* (EHB cost sharing requirement) and *42 U.S.C. § 300gg-13*; *45 C.F.R. § 147.130* (preventive services cost sharing prohibition). For special rules regarding emergency services, see *45 C.F.R. § 147.138(b)(3)*, and for mental health parity rules, see *Treas. Reg. § 54.9812-1T(b)*, (c).

Importantly, these limits apply to all (non-grandfathered) group health plans (including self-funded plans) that provide benefits in one or more EHB categories, regardless of whether the plan is subject to mandatory EHB package coverage or is voluntarily offering an EHB benefit. *78 Fed. Reg. 12,834, 12,837–38 (Feb. 25, 2013)*.

Definition of Cost Sharing

Cost sharing includes any portion of the cost of a benefit that the insured must pay (instead of the plan), typically in the form of deductibles, coinsurance, and copayments. Subject to the exceptions noted below, it includes any cost borne by an insured individual for an EHB qualified medical expense (within the meaning of *I.R.C. § 223(d)(2)*). These are frequently referred to as out-of-pocket (OOP) expenses. The exceptions to the broad definition are:

- Premiums
- Balance billing amounts for non-network providers (described below)
- Spending for services not covered by the plan

42 U.S.C. § 18022(c)(3).

Balance billing refers to charging patients for the difference between an out-of-network provider's billed charges and the sum of the amount collected from the plan plus the cost sharing amount. Such charges may be ignored for purposes of the cost sharing limits. Reference billing is also permitted, where costs in excess of a reference amount for a service are passed on to the patient if the plan has a network of providers that agree to accept the reference amount as full payment. Plans using this design need to comply with rules ensuring covered individuals have adequate access to quality providers. See *FAQS about Affordable Care Act Implementation (Part XXI)*, Q&A-1.

Separate cost sharing limitations on deductibles, originally part of the ACA, were repealed in 2014 (*Pub. L. No. 113-93*).

Cost Sharing Limits

Cost sharing limits were set in 2014 at the level of the maximum deductible allowed for high deductible health plans (HDHPs) under *I.R.C. § 223(c)(2)(A)(ii)* and are adjusted annually for later years to reflect health care inflation as determined by the premium adjustment percentage defined in *42 U.S.C. § 10822(c)(4)*. As a result, the cost sharing limits for years after 2014 are different than the ones for HDHPs, which use a different inflation adjustment method.

There are two limits, one for self-only coverage ($7,900 for 2019 and $8,150 for 2020) and one for all other levels of coverage ($15,800 for 2019 and $16,300 for 2020), but they are not mutually exclusive. That is, even if an individual has family coverage (or other non-self-only coverage), that individual cannot be charged OOP expenses for EHB over the self-only coverage limit, while the non-self-only coverage limit applies for all individuals' OOP expenses in the aggregate for the plan year. When reviewing plan documents or auditing administrative procedures for cost sharing compliance, be sure the provisions applying this rule are clearly expressed and correctly implemented. See *FAQS about Affordable Care Act Implementation (Part XXVII)*, Q&A-1.

These ACA cost sharing limits only apply to the EHB under the plan (on an aggregate basis), so it is permissible to have higher OOP costs for non-EHB benefits.

For more information on these rules, see *ACA Cost Sharing Rules*

Separate Rule for Certain Preventive Services

All cost sharing is prohibited for EHB that fall within the recommended preventive services described in *45 C.F.R. § 147.130*. For more information, see *ACA Preventive Services Coverage Rules*

Annual and Lifetime Limits for EHBs

Since 2014, all non-grandfathered group health plans (whether or not subject to the mandatory EHB coverage requirement) have been prohibited from applying any dollar limit on EHB benefits available under the plan. *42 U.S.C. §300gg-11(a)*; *45 C.F.R. § 147.126(a)*.

The limits specifically apply to dollar-based annual or lifetime caps. The rules permit plans to impose quantitative limitations (e.g., a maximum number of office visits per year), unless the restriction indirectly acts as a dollar limit.

For example, a limitation of a specified dollar amount per day is prohibited since it implies an annual or lifetime dollar limit. A dollar limit per visit could be permissible unless the plan also limits the number of annual or lifetime visits.

Unless it is specified in an applicable EHB benchmark plan, a plan can exclude all benefits for a condition without that exclusion being considered an impermissible dollar limitation. Further, dollar and/or quantitative treatment limitations are permissible for non-EHB benefits. *45 C.F.R. § 147.126(b)*.

All of the foregoing is subject to state regulation (unless exempt) and other applicable federal laws.

Cost Sharing and Benefit Limit Compliance for Plans Not Subject to Mandatory EHB Coverage

Although self-funded group health plans, large group market plans, and grandfathered plans are not required to provide an EHB package, they invariably offer at least some benefits that are in the 10 EHB categories (e.g., preventive services). To the extent they do, the EHB cost sharing and benefit limit rules apply to those benefits if they are EHB.

To determine which of their benefits qualify as EHB, self-funded, large group market, and grandfathered plans generally must select any authorized EHB benchmark plan (as described earlier in this practice note in the section entitled “States’ Role in Establishing EHB”) for comparison. See *Frequently Asked Questions on Essential Health Benefits Bulletin*, Q&A-10, and *FAQS about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation*, Q&A-2; *45 C.F.R. § 147.126*; *29 C.F.R. § 2590.715-2711*. The benchmark plan can be from any state, without regard to whether the employer or a group of employees are located there. Note that if a self-funded, large group market, and grandfathered plan does not impose either cost sharing or annual or lifetime dollar limits for the potential EHB benefits, there is no need to identify a benchmarking plan since the design would necessarily be compliant.

Actuarial Value and Metal Categories

An EHB package for a plan subject to the EHB coverage mandate must provide for benefits that have a minimum actuarial value (AV). The AV is expressed as a percentage representing the proportion of the costs of the plan’s EHB that would, on average, be borne by the plan (as opposed to by the participant through cost sharing). The calculation is based on a hypothetical standard population’s use of EHB, not on actual plan experience. *42 U.S.C. § 18022(d)*.

The AV level of the plan determines the plan’s metal category—bronze, silver, gold, or platinum. The metal categories were designed to facilitation comparison shopping by consumers, and all QHPs must determine their AV and disclose their metal category. The metal levels correspond to AV percentages as follows:

- Bronze: 60%
- Silver: 70%
- Gold: 80%
- Platinum: 90%

42 U.S.C. § 18022(d)(1); *45 C.F.R. § 156.140*.

A de minimis variation in AV is allowable. Regulations modifying the de minimis standard from +/-2% to +2%/-4% were issued in *82 Fed. Reg. 18,346 (Apr. 18, 2017)*. (An even more favorable range of +4%/-5% was established for certain HDHP bronze plans. *81 Fed. Reg. 94,058 (Dec. 22, 3016)*.)

Calculating AV

Plans subject to the EHB coverage mandate must use the HHS AV calculator (2019 AV Calculator) to determine the plan's AV. But if the plan design is not compatible with the calculator, AV must be certified by a qualified actuary. The determination must be based on a standard population data set that was derived from national average spending by a wide range of consumers or, with permission from HHS, a data set specific to the state. *45 C.F.R. § 156.135*. For more information, see *CMS, Final 2019 Actuarial Value Calculator Methodology* and, for the 2020 benefit year, *CMS, Final 2020 Actuarial Value Calculator Methodology*.

These rules do not apply to plans that are not subject to the EHB coverage mandate (such as self-funded plans and large group market plans). Employer plans in this category do need to offer their full-time employees plans meeting a minimum value of 60% to avoid the employer shared responsibility penalties under *I.R.C. § 4980H(b)*. Although the calculation method is similar, an MV percentage is not necessarily comparable to an AV percentage, since AV is determined based on EHB costs, whereas MV is determined based on the benefits provided under the employer plan, which may not include all EHB.

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