

SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) In General- In this division, the term ‘essential benefits package’ means health benefits coverage, consistent with standards adopted under section 224, to ensure the provision of quality health care and financial security, that--

- (1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;
- (2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);
- (3) does not impose any annual or lifetime limit on the coverage of covered health care items and services;
- (4) complies with section 215(a) (relating to network adequacy); and
- (5) is equivalent in its scope of benefits, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage in Y1.

In order to carry out paragraph (5), the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Health Benefits Advisory Committee and to the Secretary of Health and Human Services.

(b) Minimum Services To Be Covered- Subject to subsection (d), the items and services described in this subsection are the following:

- (1) Hospitalization.
- (2) Outpatient hospital and outpatient clinic services, including emergency department services.
- (3) Professional services of physicians and other health professionals.
- (4) Such services, equipment, and supplies incident to the services of a physician’s or a health professional’s delivery of care in institutional settings, physician offices, patients’ homes or place of residence, or other settings, as appropriate.
- (5) Prescription drugs.
- (6) Rehabilitative and habilitative services.
- (7) Mental health and substance use disorder services, including behavioral health treatments.
- (8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.
- (9) Maternity care.

(10) Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

(c) Requirements Relating to Cost-Sharing and Minimum Actuarial Value-

(1) NO COST-SHARING FOR PREVENTIVE SERVICES- There shall be no cost-sharing under the essential benefits package for--

(A) preventive items and services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention; or

(B) well-baby and well-child care.

(2) ANNUAL LIMITATION-

(A) ANNUAL LIMITATION- The cost-sharing incurred under the essential benefits package with respect to an individual (or family) for a year does not exceed the applicable level specified in subparagraph (B).

(B) APPLICABLE LEVEL- The applicable level specified in this subparagraph for Y1 is not to exceed \$5,000 for an individual and not to exceed \$10,000 for a family. Such levels shall be increased (rounded to the nearest \$100) for each subsequent year by the annual percentage increase in the enrollment-weighted average of premium increases for basic plans applicable to such year, except that Secretary shall adjust such increase to ensure that the applicable level specified in this subparagraph meets the minimum actuarial value required under paragraph (3).

(C) USE OF COPAYMENTS- In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(3) MINIMUM ACTUARIAL VALUE-

(A) IN GENERAL- The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

(B) REFERENCE BENEFITS PACKAGE DESCRIBED- The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

(d) Assessment and Counseling for Domestic Violence- The Secretary shall support the need for an assessment and brief counseling for domestic violence as part of a behavioral health assessment or primary care visit and determine the appropriate coverage for such assessment and counseling.

(e) Abortion Coverage Prohibited as Part of Minimum Benefits Package-

(1) PROHIBITION OF REQUIRED COVERAGE- The Health Benefits Advisory Committee may not recommend under section 223(b), and the Secretary may not adopt in standards under section 224(b), the services described in paragraph (4)(A) or (4)(B) as part of the essential benefits package and the Commissioner may not require such services for qualified health benefits plans to participate in the Health Insurance Exchange.

(2) VOLUNTARY CHOICE OF COVERAGE BY PLAN- In the case of a qualified health benefits plan, the plan is not required (or prohibited) under this Act from providing coverage of services described in paragraph (4)(A) or (4)(B) and the QHBP offering entity shall determine whether such coverage is provided.

(3) ABORTION SERVICES-

(A) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED-

The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(B) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED-

The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(f) Report Regarding Inclusion of Oral Health Care in Essential Benefits Package- Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable oral health care to adults as part of the essential benefits package.