

SEC. 303. BENEFITS PACKAGE LEVELS.

(a) In General- The Commissioner shall specify the benefits to be made available under Exchange-participating health benefits plans during each plan year, consistent with subtitle C of title II and this section.

(b) Limitation on Health Benefits Plans Offered by Offering Entities- The Commissioner may not enter into a contract with a QHBP offering entity under section 304(c) for the offering of an Exchange-participating health benefits plan in a service area unless the following requirements are met:

(1) REQUIRED OFFERING OF BASIC PLAN- The entity offers only one basic plan for such service area.

(2) OPTIONAL OFFERING OF ENHANCED PLAN- If and only if the entity offers a basic plan for such service area, the entity may offer one enhanced plan for such area.

(3) OPTIONAL OFFERING OF PREMIUM PLAN- If and only if the entity offers an enhanced plan for such service area, the entity may offer one premium plan for such area.

(4) OPTIONAL OFFERING OF PREMIUM-PLUS PLANS- If and only if the entity offers a premium plan for such service area, the entity may offer one or more premium-plus plans for such area.

All such plans may be offered under a single contract with the Commissioner.

(c) Specification of Benefit Levels for Plans-

(1) IN GENERAL- The Commissioner shall establish the following standards consistent with this subsection and title II:

(A) BASIC, ENHANCED, AND PREMIUM PLANS- Standards for 3 levels of Exchange-participating health benefits plans: basic, enhanced, and premium (in this division referred to as a 'basic plan', 'enhanced plan', and 'premium plan', respectively).

(B) PREMIUM-PLUS PLAN BENEFITS- Standards for additional benefits that may be offered, consistent with this subsection and subtitle C of title II, under a premium plan (such a plan with additional benefits referred to in this division as a 'premium-plus plan') .

(2) BASIC PLAN-

(A) IN GENERAL- A basic plan shall offer the essential benefits package required under title II for a qualified health benefits plan with an actuarial value of 70 percent of the full actuarial value of the benefits provided under the reference benefits package.

(B) TIERED COST-SHARING FOR AFFORDABLE CREDIT ELIGIBLE INDIVIDUALS- In the case of an affordable credit eligible individual (as defined in section 342(a)(1)) enrolled in an Exchange-participating health benefits plan, the benefits under a basic plan are

modified to provide for the reduced cost-sharing for the income tier applicable to the individual under section 324(c).

(3) ENHANCED PLAN- An enhanced plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title II consistent with section 223(b)(5)(A).

(4) PREMIUM PLAN- A premium plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title II consistent with section 223(b)(5)(B).

(5) PREMIUM-PLUS PLAN- A premium-plus plan is a premium plan that also provides additional benefits, such as adult oral health and vision care, approved by the Commissioner. The portion of the premium that is attributable to such additional benefits shall be separately specified.

(6) RANGE OF PERMISSIBLE VARIATION IN COST-SHARING- The Commissioner shall establish a permissible range of variation of cost-sharing for each basic, enhanced, and premium plan, except with respect to any benefit for which there is no cost-sharing permitted under the essential benefits package. Such variation shall permit a variation of not more than plus (or minus) 10 percent in cost-sharing with respect to each benefit category specified under section 222. Nothing in this subtitle shall be construed as prohibiting tiering in cost-sharing, including through preferred and participating providers and prescription drugs. In applying this paragraph, a health benefits plan may increase the cost-sharing by 10 percent within each category or tier, as applicable, and may decrease or eliminate cost-sharing in any category or tier as compared to the essential benefits package.

(d) Treatment of State Benefit Mandates- Insofar as a State requires a health insurance issuer offering health insurance coverage to include benefits beyond the essential benefits package, such requirement shall continue to apply to an Exchange-participating health benefits plan, if the State has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any net increase in affordability premium credits under subtitle C as a result of an increase in premium in basic plans as a result of application of such requirement.