

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term “health plan” means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. [42 U.S.C. 18022] ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, 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 Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) **RULE OF CONSTRUCTION.**—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) **REQUIREMENTS RELATING TO COST-SHARING.**—

(1) **ANNUAL LIMITATION ON COST-SHARING.**—

(A) **2014.**—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) **2015 AND LATER.**—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).