Essential Health Benefits, Actuarial Value & Accreditation Standards

DEPARTMENT OF HEALTH & HUMAN SERVICES

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Consumer Information & Insurance Oversight

Introduction

- Under the Affordable Care Act:
  - Non-grandfathered health plans offered in the individual and small group markets (inside and outside of the Exchanges) must cover the essential health benefits package, which includes:
    - Covering essential health benefits (EHB)
    - Meeting certain actuarial value (AV) standards
    - Meeting certain limits on cost sharing
  - Qualified health plans (QHPs) must secure accreditation on the basis of local performance from recognized accrediting entities
- The purpose is to improve the consumer's coverage and health plan selection experience

Key Topics Covered in the Final Rule

- State-Selected and Default Base-Benchmark Plans
- EHB-Benchmark Plan Standards
- Provision of EHB
- EHB Prescription Drug Benefit
- Non-Discrimination
- Cost-Sharing Limits
- Calculation of Actuarial Value
- Determination of Minimum Value
- Provisions for Stand-Alone Dental Plans
- Accreditation Timeline for QHPs

Background on Essential Health Benefits

The ACA states that EHB must cover at least the following 10 categories of benefits & services:

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

Approach for Essential Health Benefits

- HHS's approach balances:[1]

  1. Comprehensiveness
  2. Affordability
  3. State flexibility
  4. Reflects a typical employer plan

[1] The Institute of Medicine report is available at: http://www bls gov/ncs/ebs/sp/selmedbensreport pdf

Benchmark Plan Approach for Essential Health Benefits

- Final Rule: Defines EHB based on a base-benchmark plan selected by each state
  - Benchmark options include plans typically offered by small employers
  - Preserves state flexibility
  - Similar to the benchmark approach currently used in other programs

State-Selection of Base-Benchmark Plan

State-Selection of Base-Benchmark Plan:

- 2014 & 2015: States had four options for selecting a base-benchmark plan
- If a state did not select a base-benchmark plan, the default benchmark became the largest state small group plan by enrollment
- All base-benchmarks are included in Appendix A

The list of potential default benchmark plans is available at: http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF

State Base-Benchmark Plan Options

States selected among:

1. The largest plan within one of the state's three largest small group products
2. One of the state's three largest state employee plans
3. One of the three largest federal employee plans
4. The largest HMO plan offered in the state's non-Medicaid commercial market

Supplementing the State Base-Benchmark Plan to State's EHB-Benchmark Plan

- The EHB-benchmark plan serves as a reference plan:
  - Plan benefits must be "substantially equal" to the benchmark's benefits
  - Reflect both scope of services & limits

- Plans must cover all 10 statutory categories
  - A base-benchmark plan that lacks a statutory category must supplement category from another benchmark plan option

Supplementing Options for Pediatric Oral & Vision

- A number of states' base-benchmark plans did not include coverage of pediatric oral & vision care
- The final rule allows the state's base-benchmark plan to be supplemented with:
  - The FEDVIP pediatric vision/dental plan; or
  - The state's separate CHIP plan benefit, if one exists
- Pediatric services are services for individuals under age 19
  - States have flexibility to extend beyond

Supplementing Options for Habilitative Services

- A number of states' base-benchmark plans did not include habilitative services
- If a state's base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included
- If a state's base-benchmark plan does not include coverage for habilitative services and the State did not define, insurers must:
  - Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or
  - Decide what services to cover & report to HHS

State-Required Benefits in EHB-Benchmark Plan

- ACA allows states to require benefits in addition to EHB
  - States must "defray costs" for these benefits
  - State-required benefits enacted on or before December 31, 2011 are not considered in addition to EHB
- EHB standards apply for at least 2014 & 2015 plan years
  - Accommodates current markets
  - Limits market disruption
- The Exchange is responsible for identifying which additional state-required benefits are in excess of EHB

Options for Prescription Drug Benefit

- Plans must cover at least the greater of:
  - One drug in every USP category & class; or
  - The same number of drugs in the EHB-benchmark plan
- Requires an exceptions procedure
- Applies discrimination protections
- Requires plans to report drug lists to the Exchange, state, or OPM

Requirements for Mental Health and Substance Abuse Benefits

- Plans must comply with parity standards for the mental health & substance abuse use disorder benefit
  - Based on requirements in Mental Health Parity and Addiction Equity Act of 2008

Overview of States' EHB-Benchmark Plan Selection

Type of Plan	States
Largest Small Group Plan	AL, AK, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA , KS, KY, LA, ME, MD, MA, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, VT, VA, WA, WV, WI, WY
Largest State Employee Plan	AZ, UT
Largest National FEHBP Plan	AS, GU, MP, VI
Largest State non-Medicaid HMO	CT, MI, ND

Consumer Resource: Actuarial Value

- AV standards will help consumers compare health plans by providing information about relative plan generosity

$$\frac{\text{(Total Overall Health Costs – Total Enrollee Cost Sharing)}}{\text{Total Overall Health Costs}}$$

- AV must be calculated based on the provision of EHB to a standard population
- AV is reflected as a percentage

AV Levels of Coverage

- AV determines a health plan's metal level tier
- ACA - directs that non-grandfathered individual & small group plans inside & outside the Exchanges meet particular AV targets (or be a catastrophic plan[1]):
  - Bronze = 60% AV
  - Silver = 70% AV
  - Gold = 80% AV
  - Platinum = 90% AV
- Allows for a de minimis range of -/+ 2% points

[1] Catastrophic plans are only available for certain eligible individuals

Approach for Calculating AV

- For standard plan designs, health plans will determine AV using an HHS-developed AV calculator
  - AV Calculator will guarantee plans with the same cost sharing structure will have the same actuarial value (regardless of plan discounts or utilization estimates)

- If an issuer determines that a material aspect of its plan design cannot be accommodated by the AV Calculator, HHS allows for alternative calculation methods supported by certification from an actuary

- States will have the option to submit state-specific data sets starting 2015

Determining Minimum Value

- A group health plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan is no less than 60%
- An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits
- A group health plan may determine if it provides MV using the following methods:
  - MV Calculator
  - A safe harbor established by HHS and IRS
  - Certification by an actuary if neither is suitable

Consumer Protections: Non-Discrimination Standards

- The final rule prohibits benefit design discrimination based on:
  - Age
  - Expected length of life
  - Disability
  - Medical dependency
  - Quality of life
  - Other health conditions

- Allows for reasonable medical management techniques

Consumer Protections: Cost-Sharing

On or after January 1, 2014:

- Provides annual limits on maximum out-of-pocket (MOOP) for all group health plans (including large and self-insured):
  - Equal to IRS annual dollar limit for a HDHP for self-only coverage; or
  - Equal to IRS annual dollar limit for a HDHP for other than self only coverage
- Provides annual limits on deductibles for small group plan market:
  - $2,000 for self-only coverage
  - $4,000 for other than self-only coverage

For subsequent plan years:

- Will increase based on a premium adjustment %

Applies to in-network costs

Stand-Alone Dental Plans (SADP)

- QHPs in an Exchange may omit the pediatric dental EHB if a SADP in that Exchange offers the pediatric dental EHB
- Outside of the Exchanges, plans may offer EHB that exclude pediatric dental coverage if:
  - "reasonably assured" that coverage is only sold to individuals who purchase coverage through an Exchange-certified SADP
- SADPs are allowed a separate out-of-pocket maximum
  - Required to demonstrate the out-of-pocket maximum is reasonable for pediatric dental EHB
- Exchanges determine what is a reasonable out-of-pocket maximum

AV Standards for Stand-Alone Dental Plans

- SADP cannot use the AV Calculator
- Must demonstrate that the plan offers pediatric dental essential heath benefits at:
  - A low level of coverage – 70%
  - A high level of coverage – 85%
- Allows for a de minimis range of -/+ 2% points
- Must be certified by an actuary

Consumer Protections: Accreditation Standards

- Recognition of accrediting entities is applicable for all qualified health plans, regardless of the type of Exchange that certifies the QHPs
- The final rule:
  - Provides a timeline for the accreditation requirement for issuers offering QHPs in a Federally-facilitated Exchange, including a State Partnership Exchange
  - Provides an application process for additional accrediting entities to be recognized for QHP certification
- In future rulemaking, HHS intends to establish:
  - A phase two recognition process which may establish additional criteria for recognized accrediting entities to provide the accreditation required for QHPs

Timeline for Accreditation Requirement in an FFE/Partnership

Certification	QHP Issuers Without Existing Accreditation	QHP Issuers With Existing Commercial/Medicaid Accreditation in the State
Year 1 (2013)	Schedule or plan to schedule accreditation review	Existing accreditation accepted
Years 2 & 3 (2014 & 2015)	QHP policies & procedures must be accredited	Existing accreditation accepted if accredited policies & procedures are the same or similar to the QHP
Year 4 (2016)	QHP issuer must be accredited in accordance with 45 CFR 156 275	

Application Process for Accrediting Entities

- Amends “phase one” recognition process to allow additional accrediting entities to apply to be recognized as accrediting entities for the purposes of QHP certification
  - “Phase One” process recognizes the National Committee for Quality Assurance (NCQA) & URAC, made official in a Federal Register Notice published in November 2012
- Application & review process
  - Applicant must demonstrate how the accrediting entity meets requirements of 45 CFR 156 275 (c)(2)-(3) & provide the documentation required by (c)(4)
  - Within 60 days of receiving the complete application, HHS will publish a notice identifying the applicant, summarizing its analysis of whether the applicant meets the criteria, & providing no less than a 30-day public comment period
  - After close of the comment period, HHS will notify the public in the Federal Register the names of the accrediting entities recognized & those not recognized to provide accreditation of QHPs

Changes in the Final Rule

- Defined the application of default base-benchmark plans in the U.S. territories
- Clarified that an EHB plan cannot exclude an enrollee from any EHB category except pediatric services
- Expressly stated enrollees' ability to access clinically appropriate drugs
- Clarified that reasonable medical management techniques are permitted under the non-discrimination policy
- Clarified the non-discrimination policy's application on the cost-sharing requirements
- Unlocked final version of AV calculator
- Modified lower AV level for SADPs