

Essential Health Benefits, Actuarial Value & Accreditation Standards

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS for MEDICARE & MEDICAID SERVICES
Center for Consumer Information and Insurance Oversight



Introduction

- The Affordable Care Act ensures Americans have access to quality, affordable health insurance.
 - The law ensures non-grandfathered health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges, cover a core package of items and services, known as **essential health benefits (EHB)**.
 - Non-grandfathered health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges, will be offered at certain **actuarial value (AV)**, or metal, levels.
 - Qualified health plans (QHPs) must secure accreditation on the basis of local performance from **recognized accrediting entities**, on a timeline established by each Exchange that certifies the qualified health plan.
- Together, these standards will help consumers become more confident in comparing and selecting health plans based on factors that are important to themselves and their families.

Background on Essential Health Benefits

The Affordable Care Act states that EHB must cover at least the following 10 categories of benefits and services:

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

Background on Essential Health Benefits, contd.

- In addition to covering at least the 10 statutory categories, EHB must:
 - Be equal in scope to benefits covered under a typical employer plan.
 - Reflect balance among the 10 categories of benefits.
 - Not be designed to discriminate or allow denials based on age, disability or expected length of life.
 - Take into account the health care needs of diverse segments of the population.
- The following plans must cover EHB:
 - Non-grandfathered health insurance plans in the individual and small group markets both inside and outside of the Exchanges.
 - Multi-State plans (MSPs) offered under contract with the Office of Personnel Management, Medicaid benchmark and benchmark-equivalent plans, and Basic Health Programs (BHPs), if applicable.
 - *Guidance on the application of EHB to MSPs and BHPs is not in this NPRM.*
 - *Guidance on the application of EHB to Medicaid is in the Medicaid SMD letter.*

Proposed Benchmark Approach

- HHS took into consideration a report from the IOM¹ that recommended a process for defining EHB. The report recommended a balance between comprehensiveness, affordability, and state flexibility.
- The proposed EHB benchmark approach incorporates plans typically offered by small employers, and benefits that are covered in the current employer marketplace.
- The rule proposes to define EHB based on a benchmark plan selected by each state or a default benchmark set forth in the proposed rule if a state does not make a selection. This approach preserves state flexibility and is similar to the benchmark approach currently used in other programs.
- The EHB benchmark plan will serve as a reference plan, reflecting both scope of services and limits offered by a typical employer plan in that state.

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

Proposed Benchmark Plan Options

States will select a plan among one of four options:

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; or
4. The largest HMO plan offered in the state's non-Medicaid commercial market.

Proposed Process for Benchmark Selection

- State selects a single benchmark (based on the four options outlined) for the commercial market for 2014 and 2015, which will define the set of benefits all applicable individual small group plans must provide.
- The benchmark options will be based on enrollment as of March 31, 2012.
- If a state does not exercise the option to select a benchmark health plan, the default benchmark plan for that state will be the largest small group plan by enrollment.
- On July 2, 2012, HHS updated and released a list of potential default benchmark plans.
- All state-selected benchmarks and benchmarks determined by the Secretary will be posted in the rule for notice and comment and will be finalized after a 30-day comment period. We encourage states and stakeholders to comment on the proposed benchmark during this time.

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

Proposed EHB Benchmark Coverage

- Plans that cover EHB must provide coverage for all 10 statutory categories and offer benefits that are substantially equal to the benchmark plan.
- If a benchmark is lacking a statutory category, it must be supplemented from another benchmark plan option.
- If a benchmark plan does not include pediatric oral or vision services, the plan must be supplemented with the FEDVIP pediatric vision/dental plan or the state's separate CHIP plan benefit, if it exists.
- Mental health and substance abuse parity applies under EHB.
- If the EHB plan does not include coverage for habilitative services and the state does not define these benefits, the plan must include habilitative services that are determined by the issuer or provide parity for habilitative services that are equal in scope of coverage for rehabilitative services.

Proposed Non-Discrimination Standards

- The proposed rule includes a number of standards to protect consumers, including non-discrimination standards.
- The rule proposes to prohibit benefit designs or the implementation of benefit designs that substantially discourages enrollment based on age, expected length of life, disability, medical dependency, quality of life, or other health conditions.

Proposed Prescription Drug Coverage

- It is proposed that a plan cover, as a minimum standard, the greater of one drug in every category and class or the same number of drugs in the benchmark plan.
- A plan must report its drug coverage to the Exchange, state, HHS, or OPM, depending on the type of Exchange and plan.
- The USP classification system is being considered as a common organizational tool for plans to report drug coverage.
- A plan may add or remove drugs on its list as long as the plan retains the minimum number per category and class. A plan is not obligated to cover the same drugs as the benchmark plan as long as it covers the same number of drugs.
- It is proposed that drugs listed must be chemically distinct.

Actuarial Value Background

- AV standards will help consumers compare health plans by providing information about relative plan generosity.
- The Affordable Care Act directs that non-grandfathered individual and small group plans inside and outside the Exchanges meet particular actuarial value (AV) targets described below or be a catastrophic plan available only to certain eligible individuals.
 - Bronze = 60% AV
 - Silver = 70% AV
 - Gold = 80% AV
 - Platinum = 90% AV
- AV must be calculated based on the provision of EHB to a standard population.

Proposed Approach for Calculating AV

- Health plans and states will determine AV using an HHS-developed AV calculator.
- State regulators can verify AV for the following, using this calculator:
 - QHPs in State-based Exchanges
 - QHPs for State Partnerships
 - Health plans outside the Exchange that are required to comply with AV standards
- For plan types with non-standard features (e.g., value-based insurance designs), HHS proposes that plans make adjustments separate from the calculator, requiring certification from an actuary.
- States will have the option to submit state-specific data sets starting 2015.
- Issuers may use the AV calculator for informal calculations to design plans prior to submitting final plan design and AV for approval.

Proposed Accreditation Standards

- The rule proposes a timeline for the accreditation requirement for issuers offering QHPs in a Federally-facilitated Exchange or State Partnership Exchange, and provides an application process for additional accrediting entities to be recognized for the purposes of providing accreditation to fulfill the requirements for QHP certification.
- HHS intends, through future rulemaking, to establish a phase two recognition process which may establish additional criteria for recognized accrediting entities to provide the accreditation required for QHPs.

Proposed 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 and 3 (2014 & 2015) | QHP policies and procedures must be accredited | Existing accreditation accepted if accredited policies and procedures comparable to QHP |
| Year 4 (2016) | QHP issuer must be accredited in accordance with 45 CFR 156.275 | |

Proposed Application Process for Recognizing Additional 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) and URAC, made official in a Federal Register Notice published concurrently with this rule.
- Application and review process
 - Applicant must demonstrate how the accrediting entity meets requirements of 45 CFR 156.275 (c)(2)-(3) and 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, and 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 and those not recognized to provide accreditation of QHPs.

Next Steps

- The NPRM displayed in the Federal Register on November 20, 2012 at <http://www.ofr.gov/inspection.aspx>.
- We welcome comments on the proposed rule to assist us in fully considering issues and developing policies.
- All comments are due by **11:59 p.m. ET, December 26, 2012**.
- Comments can be submitted either electronically at <http://www.regulations.gov> or through regular mail at:

Centers for Medicare & Medicaid Services, DHHS

Attention: CMS-9980-P

P.O. Box 8010

Baltimore, MD 21244-8010