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CMS Proposed Rule On Affordable Care Act Standards For Essential Health Benefits, Actuarial Value, And Accreditation

By Kevin B. Kroeker and Peter Roan, Crowell & Moring

The Patient Protection and Affordable Care Act (ACA) requires all health plans offered through Health Insurance Exchanges (Exchanges) and small group and individual products offered outside of the Exchanges to offer a core package of items and services, known as essential health benefits, and to meet specified actuarial value levels. On November 20, 2012, the U.S. Department of Health and Human Services (HHS) issued a proposed rule for the purpose of clarifying and elaborating on the requirements for offering essential health benefits and for meeting actuarial value levels. The proposed rule also sets a timeline for qualified health plans (QHPs) to be accredited in the Exchanges and a process for recognition of additional accrediting entities for purposes of certifying QHPs. The comment period expires December 26, 2012.

Essential Health Benefits

The proposed rule specifies the ten mandatory essential health benefits categories, as originally defined in the ACA, as follows:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

45 CFR § 156.110(a).

The proposed rule requires all plans that cover essential health benefits to offer benefits that are substantially equal in scope to the benefits offered by a state-specific benchmark plan. *Id.* § 156.115. If a benchmark plan lacks any of the ten statutory categories of benefits, the proposed rule directs the state or HHS to supplement the benchmark plan in that category. *Id.* § 156.110(c). States may require that a QHP cover additional benefits beyond the ten EHB categories. The state must defray the cost to the issuer of the additional required benefits, but only if the state benefit was enacted as a benefit mandate after December 31, 2011. *Id.* § 155.170(b). This limitation protects states from having to subsidize the cost of state mandated benefits, enacted before 2012, that go beyond federally mandated minimum benefits, a result that PPACA could have been construed to require. New mandates, however, will face this obstacle.

Because many health insurance plans do not identify habilitative services as a distinct group of services, the proposed rule allows states the opportunity to define these services if they are not currently included in the base-benchmark plan. *Id.* § 156.110(f). If the state does not define habilitative services, issuers must provide coverage at parity with rehabilitative services or as determined by the issuer and reported to HHS. *Id.* § 156.115(a)(4).

The proposed rule requires states to choose essential health benefits benchmark plans to serve as reference plans that reflect both the scope of services and benefit limits offered by a typical employer plan in the state. States may select a benchmark plan from among four options: (1) one of the three largest small group plans in the state; (2) one of the three largest state employee health plans; (3) one of the three largest federal employee health plan options; or (4) the largest health maintenance organization plan offered in the state's commercial market. *Id.* § 156.100(a). If a state does not make a selection, HHS will choose as the default benchmark the largest small group product in the state. *Id.* § 156.100(c).

The proposed rule includes a number of standards to protect consumers against discrimination and ensure that benchmark plans offer a full array of essential health benefits. For example, the proposed rule prohibits benefit designs that could discriminate against potential or current enrollees based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. *Id.* § 156.125(a).

The proposed rule also includes standards for prescription drug coverage. Plans must offer the greater of one drug in every United States Pharmacopeia (USP) category or class or the number of drugs in each category and class as offered by the essential health

benefits benchmark plans. *Id.* § 156.120(a). Issuers are not required to cover the same drugs as are covered by the benchmark plan as long as they cover the minimum number of drugs in each category.

Actuarial Value

For purposes of determining whether a plan offers essential health benefits, the proposed rule contains requirements for health insurance issuers to determine actuarial value. Actuarial value (AV) is a measure of the percentage of expected healthcare costs a health plan will cover for a standard population. *Id.* § 156.20. For example, if a plan has an AV of 60%, that means a patient would be responsible for 40% of the cost of benefits covered by the plan. Beginning in 2014, health plans must meet an AV that matches up to a specified level of coverage—bronze (60%), silver (70%), gold (80%), or platinum (90%). *Id.* §156.140(b). The proposed rule permits a plan to qualify for a particular "metal level" if the difference in the true dollar value is within 2 percentage points. *Id.* (c).

The proposed rule outlines an approach for issuers to calculate the AV for each plan. *Id.* § 156.135. HHS developed a proposed actuarial value calculator, and issuers must use this calculator unless the plan's design is not compatible with its use. *Id.* (b). (The AV calculator can be found at http://cciio.cms.gov/resources/regulations/index.html#pm.) If a plan is not compatible with the AV calculator, the issuer has two options: (1) estimate the plan's fit into the AV calculator parameters, or (2) use the AV calculator for compatible plan provisions and use an actuary to adjust the actuarial value for the plan's incompatible parts. *Id.* The AV calculator will use national claims data from plans with different degrees of cost-sharing as its underlying standard population. Beginning in 2015, state-specific claims data may be used if the state provides such data, and HHS approves of the data set by a date to be specified by HHS. *Id.* (d)-(e).

The proposed rule also sets annual limits on cost-sharing for stand-alone pediatric dental plans inside the Exchanges. *Id.* § 156.150. Such plans must demonstrate that they offer pediatric dental essential benefits at between 75% and 85% within plus or minus 2%. *Id.* (b).

Applicability of Essential Health Benefits and Actuarial Value Requirements Outside of the Exchange

The requirements for essential health benefits and actuarial value are also applicable to small group and individual insurance policies issued outside of the Exchanges, beginning January 1, 2014. *Id.* § 147.150. But such requirements do not apply to grandfathered

plans, defined by the ACA as an existing group health plan or health insurance coverage in which a person was enrolled on the date of ACA's enactment. *Id.* § 147.140.

Large employer and self-insured plans do not need to provide essential health benefits, but if they fail to provide plans with minimum value, their employees may go to the insurance exchange and receive premium tax credits. ACA, Pub. Law No. 111-148, § 1401(a), 124 Stat. 119 (2010). Employers may have to pay penalties to the Internal Revenue Service (IRS) if its full-time employees receive these tax credits. *Id.* § 1411(e)(4)(B)(iii). A plan provides minimum value if the total allowed costs of the benefits provided under the plan is at least 60%. *Id.* § 1401(a). The proposed rule describes acceptable methods for determining whether an employer-sponsored health plan provides minimum value. 45 CFR § 156.145(a). Issuers may calculate minimum value in several ways, including using a minimum value calculator to be made available by HHS and the IRS, complying with any safe harbor established, or certification by an actuary. *Id.* The minimum value calculator uses data from a standard population reflective of the population covered by self-insured group health plans. *Id.* (c).

Accreditation

The proposed rule requires that QHPs receive accreditation from a recognized accrediting entity and establish schedules for obtaining accreditation. *Id.* § 155.1045(a). The proposed rule also specifies a process by which an accrediting entity may apply for recognition. *Id.* § 155.1045(b). NCQA and URAC have previously been recognized as accrediting entities on an interim basis, subject to submission of required documentation.

1620 Eye Street NW
Washington, DC 20006-4010
Phone: 202-833-1100 Fax: 202-833-1105