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Employee Benefits | Life Insurance | Risk Management

TO: Clients of Sitzmann Morris & Lavis Insurance Agency

RE: Essential Health Benefits and Actuarial Value Proposed Rules

Background: Beginning in 2014, the Affordable Care Act (ACA) requires certain plans to offer a comprehensive package of items and services that meets certain actuarial value requirements, known as an essential health benefits (EHB) package. This requirement applies to non-grandfathered plans in the individual and small group markets. Additionally, ACA requires issuers offering coverage in a state insurance exchange (Exchange) to be accredited and imposes requirements for accreditation.

On November 26th proposed regulations by the Departments of Health and Human Services (HHS) were entered into the Federal Register. These regulations address essential health benefits, the actuarial value of health plans and accreditation standards.

Key Provisions:

Essential Health Benefits. The proposed rule confirms prior guidance defining EHB based on a state-specific benchmark plan and requiring all plans that cover EHB to offer benefits that are substantially equal to those offered by the benchmark plan. ACA's essential health benefits requirement applies to plans offered inside and outside of the Exchanges, which are scheduled to become effective in 2014.

Self-insured group health plans, health insurance coverage offered in the large group market and grandfathered plans are not required to cover essential health benefits. The proposed regulations indicate that these plans are also not required to comply with the deductible and cost-sharing limits imposed by the health care reform law. Grandfathered plans are exempt from these rules

and the HHS, Department of Labor and the Treasury are interpreting the limits to apply to insured plans in the small group market only.

ACA requires EHB to be equal in scope to the benefits covered by a typical employer plan. Additionally, EHB must include items and services within at least the following 10 general categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder benefits, 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.

The proposed rule adopts a benchmark approach for defining EHB. The rule proposes that each state select a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state from among the following options:

- The largest plan by enrollment in any of the three largest products in the state's small group market (if a state does not make a selection, HHS will select this option as the default benchmark for that state);
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) in the state.

The rule proposes that all plans that cover EHB must offer benefits that are substantially equal to the benefits offered by the benchmark plan. If a state selects a benchmark plan that is missing any of the 10 statutory categories of benefits, the proposed rule requires the state or HHS to supplement the benchmark plan in that category.

The proposed rule also includes a number of standards to protect consumers against discrimination and ensure that benchmark plans offer a full array of EHB benefits and services. For example, the proposed rule:

- Prohibits benefit designs that could discriminate against potential or current enrollees;
- Includes special standards and options for health plans for benefits not typically covered by individual and small group policies today, including habilitative services; and
- Includes standards for prescription drug coverage to ensure that individuals have access to needed prescription medications.

States were encouraged to submit their benchmark selections by Oct. 1, 2012 to serve as the benchmarks for 2014 and 2015. If a state wishes to make a selection or change its previous selection, it must do so by Dec. 26, 2012 (the end of the comment period for the proposed rule). More information on the benchmark plans can be found on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

Actuarial Value. Actuarial value (AV) is calculated as the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV of 70 percent, on average, a consumer would be responsible for 30 percent of the costs of all covered benefits.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain levels of AV (or "metal levels"):

- 60 percent for a bronze plan;
- 70 percent for a silver plan;
- 80 percent for a gold plan; and
- 90 percent for a platinum plan.

In addition, issuers may offer catastrophic-only coverage with lower AV for eligible individuals. "Metal levels" are intended to allow consumers to compare plans with similar levels of coverage in order to help consumers make an informed decision about their health insurance coverage.

HHS has proposed an AV calculator to help issuers determine health plan AVs based on a national, standard population. Under the proposed rule, beginning in 2015, HHS will accept state-specific data sets for the standard population if states choose to submit alternate data for the calculator. The proposed AV calculator is posted on the CCIIO website.

The proposed rules allow health plans some flexibility in meeting the metal levels if the actuarial value is within two percentage points of the standard. It would also allow issuers in the small group market to exceed annual deductible limits to achieve a particular metal level.

Accreditation standards. Finally, the rule proposes a timeline for when issuers offering coverage in a federally-facilitated exchange or state partnership exchange must become accredited. It also proposes an application process for accrediting entities seeking to be recognized to fulfill the accreditation requirements for issuers offering coverage in any exchange.

Timeline for Accreditation in a Federally-Facilitated Exchange or State Partnership Exchange

The rule proposes that a federally-facilitated exchange, including state partnership exchanges, will accept health plan accreditation from the National Committee for Quality Assurance (NCQA) and URAC on issuer's commercial or Medicaid lines of business until the fourth year of certification of a qualified health plan (QHP) (for example, 2016 certification for the 2017 coverage year). QHP issuers that do not have this existing accreditation must schedule the accreditation review in their first year of certification of the QHP (for example, 2013), and be accredited on their QHP policies and procedures in their second and third years of certification (for example, 2014 and 2015). By the fourth year of certification, QHP issuers must be accredited on the basis of local performance of its QHP.

Recognition of Additional Accrediting Entities for Purposes of QHP Certification

In a final rule published in July 2012, HHS recognized NCQA and URAC as accrediting entities for the purposes of QHP certification. The proposed rule would allow additional accrediting entities to apply to be recognized as accrediting entities. Under this proposal, HHS would provide an opportunity for public comment on the applicants being considered for recognition. After close of the comment period, HHS would notify the public of the names of the accrediting entities recognized and those not recognized for the purposes of fulfilling the accreditation requirement for QHP certification. New applicants to become accrediting entities would be evaluated using the same criteria used to recognize NCQA and URAC.

Effective dates:

These standards would be effective beginning in 2014. Because the regulations are not in final form, they do not provide definitive guidance at this point. However, they are an indicator of how HHS will apply ACA's health insurance market reforms. Comments on the proposed rule are due by Dec. 26, 2012.

What's Next:

Sitzmann Morris & Lavis Insurance Agency will continue to monitor progress of the health care reform law and its implementation and will keep you informed of important developments. As always, contact your SML Account team if you have any questions.