Bernie Lowe & Associates, Inc.
"Beyond the Product"

Health Care Reform Update

IMPORTANT NOTICE REGARDING HEALTHCARE REFORM

Update #3 **November, 2012**

Essential Benefits, Actuarial Value and Accreditation Standards

November 20, 2012, the Department of Health and Human Services (HHS) published a proposed rule that helps consumers shop for and compare non-grandfathered private health insurance options in the individual and small group markets. Specifically, this rule outlines health insurance issuer standards related to the coverage of essential health benefits (EHB) and the determination of actuarial value (AV). Additionally, the rule proposes a timeline for when issuers offering coverage in a Federally-facilitated Exchange or State Partnership Exchange must become accredited. The rule also proposes an application process for accrediting entities seeking to be recognized to fulfill the accreditation requirements for issuers offering coverage in any Exchange.

Essential Health Benefits

The Affordable Care Act ensures that health plans offered in the individual and small group markets, both inside and outside of Affordable Insurance Exchanges (Exchanges), offer a core package of items and services, known as "essential health benefits." EHB must include items and services within at least the following 10 categories:

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
10. Pediatric services, including oral and vision care

The Affordable Care Act sets forth that EHB be equal in scope to benefits offered by a "typical employer plan." To meet this requirement in every state, the proposed rule defines EHB based on a state-specific benchmark plan. The rule proposes that states select a benchmark plan from among several options identified in the proposed rule, and that all plans that cover EHB must offer benefits that are substantially equal to the benefits offered by the benchmark plan.

The benchmark plan options include:

1. the largest plan by enrollment in any of the three largest products in the state's small group market;
2. any of the largest three state employee health benefit plans options by enrollment;
3. any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or
4. the largest insured commercial HMO in the state. The proposed rule also clarifies that in the event a state does not make a selection, HHS will select as the default benchmark the largest small group product in the state, as described in option one (1) above.

If a benchmark plan is missing any of the 10 statutory categories of benefits, the proposed rule has the state or HHS 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.

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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
- Includes standards for prescription drug coverage to ensure that individuals have access to needed prescription medications.

The appendix of the proposed regulation includes the proposed list of state-selected EHB-benchmark plans, as well as the default benchmark plan for state that does not select a benchmark plan, for public comment. States can make an EHB-benchmark selection until the close of the comment period for this rule. Further information on the benchmark plans can be found on the CCIIO website.

Actuarial Value

Actuarial Value, or 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 AVs, 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" will allow consumers to compare plans with similar levels of coverage, which along with consideration of premiums, provider participation, and other factors, would help the consumer make an informed decision.

To streamline and standardize the calculation of AV for health insurance issuers, HHS is providing a publicly available AV calculator, which issuers would use to determine health plan AVs based on a national, standard population, as required by law. 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 rule includes standards and considerations for plans with benefit designs that the AV calculator cannot easily accommodate. Consumer-driven health plans, such as high-deductible health plans and health savings accounts, are compatible with the AV calculator.

HHS recognizes that health plans need some flexibility in meeting the metal levels. Therefore, they propose that a plan can meet a particular metal level if its AV is within 2 percentage points of the standard. For example, a silver plan may have an AV between 68 percent and 72 percent. In addition, the proposed rule provides flexibility for issuers in the small group market by permitting issuers to exceed annual deductible limits to achieve a particular metal level.

Accreditation Standards

Timeline for Accreditation Requirement in a Federally-facilitated Exchange and State Partnership Exchange

HHS is proposing that a Federally-facilitated Exchange, including State Partnership Exchanges, will accept existing health plan accreditation from the National Committee for Quality Assurance (NCQA) and URAC on issuer's commercial or

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Medicaid lines of business until the fourth year of certification of a qualified health plan (QHP) (e.g., 2016 certification for the 2017 coverage year). The timeline outlined in the proposed rule ensures that consumers have access to high-quality plans, but also recognizes the significant time that issuers will need to obtain accreditation. QHP issuers that do not have this existing accreditation must schedule the accreditation review in their first year of certification of the QHP (e.g., 2013), and be accredited on their QHP policies and procedures in their second and third years of certification (e.g., 2014 and 2015). By the fourth year of certification of the QHP (e.g., 2016 certification for the 2017 coverage year), QHP issuers must be accredited on the basis of local performance of its QHP.

The bulletin on EHB (December 16, 2011) is available at:
http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

The bulletin on AV and cost-sharing reductions (February 24, 2012) is available at:
http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.