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REFORM Update

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The Department of Health and Human Services (DHHS) recently published proposed rules on a number of health care reform issues. The topics include:

- Essential Health Benefits
- Actuarial Value
- Accreditations Standards
- Employer Minimum Plan Value Calculation

This *Reform Update* summarizes the details of these rules. DHHS has asked for feedback on a number of provisions by December 20, 2012. Some aspects of the guidance may change as a result of stakeholder concerns.

Essential Health Benefits

Health care reform requires individual and small group health plans to cover essential health benefits (EHBs). We summarized the initial guidance on EHBs in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2012/Reform_Update_37.pdf.

Beginning in 2014, non-grandfathered individual and small group health plans in or outside an Exchange must cover EHBs. The definition of a small group may differ from state to state. Most states will define it, in 2014 and 2015, as an employer with fewer than 50 employees. In 2016, small groups will be defined as fewer than 100 employees. Few states plan to adopt the 100-employee threshold in 2014.

In 2017, states may allow larger groups to purchase coverage through the Exchange. If a large group health plan is offered in the Exchange, it will also be required to cover EHBs. Otherwise, the requirement to cover EHBs does not apply to self-funded or large fully insured group health plans.

Requiring coverage of EHBs is intended to make individual and small group plans equivalent to the typical employer-sponsored health plans in scope and benefits. Health reform defined essential health benefits as including the following ten categories of benefits:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services, including behavioral health treatment

6. Prescription drugs
7. Rehabilitative/habilitative services and devices
8. Laboratory services
9. Preventive and wellness services including chronic disease management
10. Pediatric services, including oral and vision care

Initially, the federal government allowed the states to determine EHBs, but it did designate the plans from which a state could choose. These benchmark plan options included:

1. The largest plan by enrollment in any of the three largest products in the state's small group market.
2. Any of the three largest state employee health benefits plan options by enrollment.
3. Any of the three largest Federal Employees Health Benefits Program (FEHBP) plan options by enrollment.
4. The largest insured commercial HMO in the state.

If a state does not designate a benchmark plan, then the federal government would default to the first option above when choosing the benchmark plan for the state.

A benchmark plan **must** cover the ten categories of benefits. In some states, however, the benchmark plan may not cover all of them. In such situations, states have the option to supplement the benchmark plan. These supplemental options remain the same as in the initial guidance.

The proposed regulations provide new details on the ten EHB categories. For example, the requirement to cover pediatric services will apply to anyone under age 19. States, however, can choose to extend coverage for pediatric services beyond the age of 19.

The regulations also require EHBs to include specific preventive services with no member cost-sharing. The rules require this coverage because a benchmark plan may be grandfathered, and therefore not yet subject to the expanded preventive care coverage requirements. Since EHBs will apply to both individual and group markets, they must comply with the expanded preventive coverage requirements of health care reform.

DHHS will allow flexibility for habilitative benefits. It recognizes that most health plans do not cover or even recognize habilitative benefits. If none of a state's EHB benchmark options cover habilitative services and the state does not specify habilitative benefits, then a health insurance carrier can adopt one of the two following coverage approaches:

1. Provide parity by covering habilitative services in scope, amount and duration similar to the benefits provided for rehabilitative services.
2. Decide what habilitative services to cover and report those services to DHHS. DHHS will evaluate the reported services to further define habilitative services.

The new regulations also make it clear that plans must comply with the Mental Health Parity and Addiction Equity Act requirements when covering mental health and substance abuse services.

The regulations state that EHBs cannot exclude a member from an entire category of coverage. For example, dependent children can't be excluded from maternity care. Employers should understand that this exclusion applies **only** to essential health benefits. Thus, self-funded plans and large insured plans will not be required to cover maternity expenses for dependent children.

The new regulations also allow flexibility regarding prescription drug benefits. To control drug costs, health plans currently get discounts on preferred medications. The EHB will establish a list of covered drugs. However, it may be difficult for health plans to find preferred pricing for all the medications on that list. To comply with the EHB requirements, insurers must:

1. Cover at least one drug in every category and class ***or***
2. Cover the same number of drugs in each category and class as the EHB benchmark plan.

Qualified health plans (QHPs) will be required to submit covered drug lists to the Exchange.

In order to provide some clarity, the proposed regulations include new definitions. First, they define the "base-benchmark plan" as the benchmark plan the state selects to determine EHBs. If a state fails to select the base-benchmark plan, the default plan noted previously is used. The base-benchmark plan might not contain all the benefits required in the ten categories. It may have to be supplemented to cover services like pediatric oral and vision services.

Next, they define the "EHB benchmark plan" as the standard set of EHBs health care reform requires a QHP or insurance plan to cover. The EHB benchmark plan will serve as a reference plan, and will apply to the 2014 and 2015 benefit years. The government may alter the provisions of the EHB benchmark plan for 2016 and beyond.

The third term they define is "EHB package." This term refers to the scope of covered benefits and the associated coverage limits. An insured plan may have coverage limits that differ from the EHB benchmark plan. However, covered benefits must remain substantially equal to those the EHB package covers.

Since EHB benchmark plans will vary from state to state, insurers are wondering how multistate plans can comply. The new regulations propose that multistate plans meet the benchmark standards the Office of Personnel Management (OPM) issues for them.

In addition, the proposed rules include a number of standards to protect consumers against discrimination. These standards should ensure that the benchmark plan covers a wide array of services. EHBs must be defined so that they:

1. Reflect appropriate balance among the ten categories of required benefits.
2. Do not discriminate based on age, disability or expected length of life.
3. Take into account the health care needs of a diverse population.
4. Do not allow denial of coverage based on age, life expectancy or disability.

Insurance carriers must cover all the benefits included in the state's EHB package for non-grandfathered individuals and small group coverage. In addition, insured plans must also:

1. Meet the actuarial value requirements of the metal tiers.
2. Offer coverage that does not exceed the deductible limits outlined by health care reform.
3. Not exceed the cost-sharing limits health care reform designates.

The regulations provide more details on the deductible and cost-sharing limits for in-network benefits. The deductible and cost-sharing limits do not apply to the out-of-network level of benefits.

The deductible limits affect only individual and small group non-grandfathered health plans. These limits will be indexed annually. The deductibles in 2014 can't exceed $2,000 for single coverage and $4,000 for family coverage. However, feedback has shown many insurance carriers would not be able to offer lower-level metal tier plans and still meet the deductible limits. The proposed regulations will allow plans to exceed the annual deductible limit if the carrier cannot reasonably reach a given metal tier without doing so.

Cost-sharing is defined as ***any*** EHB ***expenditure*** required of or on behalf of an enrollee. This term includes deductibles, coinsurance, copayments or similar charges. It does not include premiums, balance-billed amounts for non-network providers and any spending for non-covered services. The annual cost-sharing limit is tied to the out-of-pocket maximums the IRS sets for qualifying high deductible health plans. These maximums are $6,250 for single coverage and $12,500 for family coverage (two or more people) in 2013. The 2014 maximums have not been released.

Cost-sharing limits clearly apply to individual and small group coverage in or out of an Exchange. Informally, the government has indicated these out of pockets limits will apply to **all plans** in 2014. Hopefully, future guidance will clarify this point.

Many states have designated their EHB benchmark plans. The appendix of the proposed rules lists the designated plans by state, and can be found at http://cciio.cms.gov/resources/data/ehb.html. These rules also extend the deadline for states to designate an EHB benchmark plan. States had until the close of the comment period on December 20, 2012.

In some cases, states may have mandated benefits that fall outside the EHB. Typically, this will apply to state mandates that became effective after December 31, 2011. The latest regulations defined state-required benefits as benefits that are specific to care, treatment or services covered. It does not apply to rules related to provider types, cost-sharing or reimbursement methods.

Health care reform requires states to cover the cost of state-mandated benefits effective after December 31, 2011 that are not included in the EHBs. The new regulations propose that the Exchange identify these mandated benefits and QHPs should calculate the cost of providing them. A member of the American Academy of Actuaries must make these cost calculations.

The Secretary of DHHS will review EHBs periodically. The Secretary may modify EHBs to cover gaps in care or advances in relevant evidence-based care standards.

Actuarial Value

To make Exchange health plans easy to compare, all plans must fall into one of the metal tiers below. The metal tiers are the four levels of benefit plans that the Exchange will offer. The metal tier is related to the actuarial value (AV) of the plan. The metal tiers and corresponding actuarial values are as follows:

Metal Tier	Actuarial Value
Platinum	90 percent
Gold	80 percent
Silver	70 percent
Bronze	60 percent

The proposed regulations define the actuarial value as the percentage of the total allowed cost of benefits the health plan pays. The total allowed cost of benefits is the anticipated covered amount paid for EHB coverage in a standard population. It is calculated by taking into account the health plan's cost-sharing divided by the total anticipated allowed charges for EHB coverage. The result is expressed as a percentage.

Plan designs may vary from the AV listed above by up to 2 percent. For example, a silver plan can have a value from 68 percent to 72 percent. The rules also explain how to calculate the value of stand-alone plans to deliver pediatric dental essential health benefits. These plans will offer a low level of coverage with an AV of 75 percent. A higher level of coverage will be set with an AV of 85 percent.

Insurance carriers may also offer catastrophic-only coverage. This coverage will have a value lower than the bronze metal tier and would be available only to the following specific individuals:

- Adults under age 30
- People who otherwise cannot afford coverage

For family catastrophic coverage, each family member must meet at least one of the criteria above to be eligible.

The new guidance explains how insurance carriers and Exchanges can determine the AV of plans they offer. To standardize and streamline the process, DHHS will provide a calculator to determine AV based on a national, standard population. In 2015, DHHS will allow states to provide an alternate data source for state-specific data to be used in the AV calculator. The AV calculator is available at the http://cciio.cms.gov/resources/regulations/index.html#pm

The insurance carrier will enter the cost-sharing parameters of the plan. The actuarial value will be measured only on the in-network level of EHBs.

The AV calculator will accommodate most plan designs. However, the government recognizes that some carriers will have plan designs the calculator cannot measure. The proposed regulations offer two options for measuring AV in this situation:

1. The health insurer can decide how to adjust the plan design (for calculation purposes only) to fit the parameters of the calculator. A certified member of the American Academy of Actuaries must affirm that the chosen method for adjusting the plan is based on generally accepted actuarial principles.
2. The health insurer may use the calculator for the plan design provisions that correspond to the parameters of the calculator. The insurer must then have a member of the American Academy of Actuaries calculate appropriate adjustments to the AV for plan design provisions that deviate substantially from the plan design entered into the calculator.

When the calculator measures the value of a high deductible health plan, any employer contributions to a health saving account (HSA) or health reimbursement arrangement (HRA) for the current year should be included in the AV.

Accreditations Standards

Exchanges will be a new marketplace for individual and small group coverage in 2014. The state, the federal government, or both will run the state Exchange. Exchanges will be responsible for certifying that the health plans they offer meet sound financial and quality benchmarks. Insurance carriers have been waiting for the government to publish the certification standards and processes.

Recognizing the tight lead-time to implement the process, DHHS is proposing a phased-in approach for accrediting QHPs in federally-facilitated Exchanges. For the first year of certification (2013 certification for the 2014 plan year), a federally-run or a state partnership Exchange will accept existing health plan accreditations. The accreditations can come from the National Committee of Quality Assurance (NCQA) or URAC for commercially insured or Medicaid lines of business. Insurers who want to be Exchange-certified in 2014 must schedule an accreditation review with NCQA or URAC in 2013.

For QHP certifications in the 2015 and 2016, a recognized accrediting agency must certify a QHP issuer. These agencies will review the insurer based on policies and procedures that apply to the state Exchange products. As an alternative, a QHP can select a recognized accrediting agency to certify its commercial or Medicaid health plan. NCQA and URAC accreditations will continue to be accepted. Health plan accreditations may also come from newly approved accrediting organizations as well.

For the 2017, QHPs must meet the actual accreditation requirements that appear in health care reform. A QHP will be accredited based on local performance in the following categories:

- Clinical quality measures, such as Health Effective Data and Information Set (HEDIS) measures
- Patient experience ratings
- Consumer access

- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs

NCQA and URAC already have QHP certification processes in place to evaluate organizations. DHHS will allow additional entities to apply for recognition as accrediting organizations. It will release the names of these applicants and allow a period for public comment. DHHS will then publish a list of acceptable and unacceptable accrediting organizations.

Employer Minimum Plan Value Calculation

The proposed rules also discuss the process employer health plans should use to calculate the minimum plan value. In 2014, employers with 50 or more full-time employees will have to decide whether to "play or pay." To "play," employers must offer full-time employees coverage that passes both the benefits and affordability tests. If employers decide not to "play," they will have to pay a penalty.

The benefits test requires the employer to offer a health plan that has at least a 60 percent benefit value. The proposed rules outline three possible ways to measure minimum value (MV).

First, the government will offer employers an MV calculator to determine the value of employer plans. The MV calculator will be similar to the AV calculator, but will measure value based on a different standard population and different continuance tables. For consumer-driven health plans, employer funding of an HSA or HRA for the current year will be used when assessing MV.

Employers who can't use the MV calculator have two options. First, DHHS and the IRS will develop safe harbor plan design checklists. The checklist will describe the cost-sharing attributes of the plan in the following four core benefit categories: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits and imaging and laboratory services. If the employer can satisfactorily complete the safe harbor checklist, then the plan will be deemed to have at least 60 percent value.

Second, if the plan has a non-standard design that the MV calculator can't measure or the design doesn't fit the safe harbor checklist parameters, the employer can obtain plan value from an actuary. This option is available **only** if a member of the Academy of Actuaries determines that no other option is feasible. The government will issue guidance on how to complete this actuarial analysis.

Measuring MV is different from measuring the AV. The MV is measured on the four core categories of benefits, which comprise the majority of group health plan spending. The AV is measured on the coverage of essential health benefits.

The MV calculator is not yet available to employers.

Concluding Thoughts

The government clarified some issues for employers and health plans regarding essential health benefits, measuring plan value and the Exchange accreditation process. It certainly has not answered all questions, but states and insurance carriers now have enough information to continue work on developing their Exchanges.

Much of these proposed regulations verify the process proposed earlier in the year on Exchanges and essential health benefits. The proposed rules include a detailed discussion of comments received thus far and the government's response to those comments. These newly proposed rules also request comments and the government may make changes based on the additional comments it receives.