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Final Rule Issued on Essential Health Benefits, Actuarial Value and Accreditation Standards

Beginning in 2014, the Affordable Care Act (ACA) requires non-grandfathered plans in the individual and small group market to offer a comprehensive package of items and services that meets certain actuarial value requirements. This comprehensive package is known as the essential health benefits (EHB) package.

Additionally, ACA requires issuers offering coverage in an ACA health insurance exchange (Exchange) to be accredited and imposes requirements for accreditation. The ACA Exchanges, or "Health Insurance Marketplaces," are scheduled to become effective in 2014.

On Feb. 25, 2013, the Department of Health and Human Services (HHS) released a **final rule** regarding ACA's essential health benefits, actuarial value and accreditation standards.

ESSENTIAL HEALTH BENEFITS

The final 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 non-grandfathered plans offered in the individual and small group markets, both inside and outside of the Exchanges. 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.

ACA requires the EHB package to be equal in scope to the benefits covered by a typical employer plan. Additionally, the EHB package 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.

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The final rule adopts the benchmark approach for defining EHB. Under this approach, each state can 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 by enrollment in the state's small group market;
- 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.

According to HHS, 26 states have selected their benchmark plan. In states that did not make a selection, the final rule confirms that HHS will select the largest plan by enrollment in the largest product by enrollment in the state's small group market as the default benchmark plan.

If a state's benchmark plan is missing any of the 10 categories of benefits, the final rule provides guidance on how the state (or HHS where the default benchmark plan applies) will supplement the benchmark plan in that category. The final 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 final rule:

- Prohibits discriminatory benefit designs;
- 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.

More information on the benchmark plans, including the benchmark plan for each state, 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.

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HHS has provided an AV calculator to help issuers determine health plan AVs based on a national, standard population. Under the final 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 final rule also includes standards and considerations for plans with benefit designs that are not easily accommodated under the AV calculator. Consumer-driven health plans, such as high-deductible health plans integrated with health savings accounts (HSAs) are compatible with the AV calculator. More information on the AV calculator is available on the CCIIO website.

The final rule allows health plans some flexibility in meeting the metal levels if the actuarial value is within two percentage points of the standard. For example, a silver plan may have an AV between 68 percent and 72 percent.

In addition, the final rule provides guidance on ACA's annual limit on out-of-pocket cost sharing. The final rule allows issuers in the small group market to exceed ACA's annual deductible limits to achieve a particular metal level.

ACCREDITATION STANDARDS

The final rule includes a timeline for when issuers offering coverage in a federally facilitated Exchange or state partnership Exchange must become accredited. It also describes 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

Under the final rule, a federally-facilitated Exchange, including a state partnership Exchange, will accept existing health plan accreditation from a recognized accrediting entity (that is, the National Committee for Quality Assurance (NCQA) and URAC for the 2013 certification year) on an 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 (for example, 2016 certification for the 2017 coverage year), QHP issuers must be accredited on the basis of local performance of its QHP.

Recognition of Additional Accrediting Entities

In guidance published in July 2012, HHS recognized NCQA and URAC as accrediting entities for the purposes of QHP certification. The final rule establishes a process for additional accrediting entities to apply to be recognized as accrediting entities. Under this process, HHS will provide an opportunity for public comment on the applicants being considered for recognition. After the close of the comment period, HHS will 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 will be evaluated using the same criteria used to recognize NCQA and URAC.

Source: U.S. Department of Health and Human Services