Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage

The health care law, the Affordable Care Act, contains a number of provisions to ensure that Americans have access to quality, affordable health insurance.

On February 20, 2013, the Department of Health and Human Services (HHS) released a final rule that helps consumers shop for and compare health insurance options in the individual and small group markets by promoting consistency across plans, protecting consumers by ensuring that plans cover a core package of items that are equal in scope to benefits offered by a typical employer plan, and limiting their out of pocket expenses.

Specifically, this rule outlines health insurance issuer standards related to the coverage of essential health benefits (EHB) and the determination of actuarial value (AV), while providing significant flexibility to states to shape how EHB are defined. Taken together, EHB and AV will significantly increase consumers' ability to compare and make an informed choice about health plans. They also extend coverage for services like mental health benefits to people with gaps in their coverage or no coverage at all.

Additionally, the rule sets forth a timeline for when issuers offering coverage in a Marketplace not operated by a state must become accredited. The rule also finalizes an application process for accrediting entities seeking to be recognized by the Secretary to fulfill the accreditation requirements for issuers offering coverage in any insurance Marketplace.

An Open, Public Process

To inform the Department's understanding of the benefits provided by employer plans, HHS considered a report on employer plans submitted by the Department of Labor (DOL), recommendations on the process for defining and updating EHB from the Institute of Medicine (IOM), and input from the public and other interested stakeholders during a series of public listening sessions. HHS commissioned the IOM to recommend a process that would help HHS define the benefits that should be included in the EHB and update the benefits to take into account advances in science, gaps in access, and the effect of any benefit changes on cost. The IOM submitted its consensus recommendations in a report entitled "Essential Health Benefits: Balancing Coverage and Cost" on October 7, 2011.[1] In order to balance the cost and comprehensiveness of EHB, the IOM recommended that EHB reflect plans in the small employer market and recommended the development of a framework for updating EHB that would take into account new evidence.

The final rule reflects extensive collaboration and work with states, small businesses, consumers, and health insurance issuers. Before issuing this proposed rule, HHS published two bulletins outlining our intended approach to EHB and AV.[2]

In November, we published a proposed rule that reflected the approach taken in the EHB bulletin and the comments received. We received public comments on the proposed rule from states, health plans, industry experts, health care providers, Members of Congress, consumer groups, and members of the public. We carefully reviewed and considered those comments in developing the final rule.

Essential Health Benefits

The Affordable Care Act ensures Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures that health plans offered in the individual and small group markets, both inside and outside of Health Insurance Marketplaces, offer a core package of items and services, known as "essential health benefits." Under the statute, 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 also directs that EHB be equal in scope to benefits offered by a "typical employer plan." To meet this requirement in every state, the final rule defines EHB based on a state-specific benchmark plan. States can select a benchmark plan from among several options, including the largest small group private health insurance plan by enrollment in the state. The final rule provides that all plans subject to EHB offer benefits substantially equal to the benefits offered by the benchmark plan. This approach best strikes the balance between comprehensiveness, affordability, and state flexibility. The final rule also gives issuers the flexibility to offer innovative benefit designs and a choice of health plans.

The benchmark plan options include: (1) the largest plan by enrollment in any of the three largest products by enrollment 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 HMO plan with the largest insured commercial non-Medicaid enrollment in the state. Twenty-six states selected their own benchmark. The final rule also clarifies that in the remaining states that do not make a selection, HHS will select the largest plan by enrollment in the largest product by enrollment in the state's small group market as the default base-benchmark plan. The selected benchmark plans are already finalized for benefit year 2014.

If a benchmark plan is missing any of the 10 statutory categories of benefits, the final rule provides direction on how the state, or HHS where the default base-benchmark plan applies, will supplement the benchmark plan in that category. The final rule also includes 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 coverage of 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.

Appendix A of the final regulation includes the final list of EHB-benchmark plans for coverage in years 2014 and 2015.

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 could expect to be responsible generally for 30 percent of the costs of all covered benefits in that plan.

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. Issuers may offer catastrophic-only coverage to eligible individuals. "Metal levels" will allow consumers to compare plans with similar levels of coverage, which along with consideration of premiums, provider networks, and other factors, 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 will use to determine health plan AVs based on a standard population, as required by law. In 2014, the AV Calculator will use a national standard population. As described in 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 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 integrated with health savings accounts, are compatible with the AV Calculator. The AV Calculator is posted on the CCIIO website.

HHS recognizes that health plans need some flexibility in meeting the metal levels. Therefore, we finalized 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 final rule provides flexibility for issuers in the small group market regarding annual deductible limits if necessary to achieve a particular metal level.

As stated in previous guidance, the health care law directs that, starting in 2014, all types of health insurance will include an annual limit on out-of-pocket cost sharing for individuals and families. While not yet set for 2014, the comparable limit this year is $6,250 for self-only coverage. This protection will ensure that Americans will no longer face medical bankruptcy even when they have health insurance. Future rulemaking and sub-regulatory guidance will be issued regarding the application of this policy to the group market.

Accreditation Standards

Timeline for Accreditation Requirement in a Certain Marketplaces

Under this rule, each non-state-based Marketplace will accept existing health plan accreditation from a recognized accrediting entity (i.e. National Committee for Quality Assurance (NCQA) and URAC for the 2013 certification year) on issuer's commercial or 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 final rule ensures that consumers in such a Marketplace have access to QHPs that meet certain standards, 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.

Recognition of Additional Accrediting Entities for the Purposes of QHP Certification

In a final rule published in July 2012, HHS recognized the NCQA and URAC as accrediting entities for the purposes of QHP certification by any Marketplace, subject to the submission of documentation.[3] HHS received that documentation and in a Federal Register Notice dated November 23, 2012, HHS recognized NCQA and URAC as accrediting entities for the purposes of QHP certification. Nothing in this final rule changes that recognition. This final rule establishes a process that allows additional accrediting entities to apply to be recognized as accrediting entities. As finalized, the rule states that HHS will provide an opportunity for public comment on the applicants being considered for recognition and, after close of the comment period; HHS would notify the public which accrediting entities were recognized and which were not recognized. New applicants to become accrediting entities would be evaluated using the same criteria used to recognize NCQA and URAC.

[1] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx
[2] The bulletin on EHB (December 16, 2011) is available at: http://cms.gov/cciio/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. The bulletin on AV and cost-sharing reductions (February 24, 2012) is available at: http://cms.gov/cciio/resources/files/Files2/02242012/Av-csr-bulletin.pdf.
[3] Final Rule published on July 20, 2012 at 77 FR 42658 – 42672.

Source: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html