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Proposed Rule: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

On November 20, the Department of Health and Human Services (HHS) posted for public inspection the above-referenced proposed rule that provides important information for states, health plans, providers, and others on the rules that will determine the benefits and costs of plans that will be offered through health insurance exchanges (Qualified Health Plans or QHPs) and for many plans sold outside of exchanges starting in 2014. In addition, the proposed rule implements section 1311 of the Affordable Care Act (ACA), which requires that QHPs be accredited on the basis of performance by an accrediting entity recognized by HHS.

The proposed rule will be published in the Federal Register on November 26, and comments are due by December 26. Although this is a proposed rule, it provides important information on the likely look of any final rule.

Executive Summary

This proposed rule builds on, and tracks closely to, guidance already provided by the Centers for Medicare & Medicaid Services (CMS) in the form of two previous Bulletins and one FAQ.[1] Because of this, the proposal contains few surprises.

For essential health benefits (EHBs), HHS proposes the approach from its Bulletin that, for 2014 and 2015, EHBs will be determined with reference to the benefits provided in one of ten possible benchmark plans selected by the state or, where a state does not make a selection, by default to the largest plan by enrollment in the largest product in the state's small group market. The proposed rule announces that states will now have until December 26 (when comments on the proposed rule are due) to select a benchmark plan or change a selection they have already made.

While not breaking much new ground, the proposed rule does provide important clarifying information in several areas, including the EHB categories of prescription drugs and habilitative services. For drugs, the proposed rule establishes a minimum standard for coverage that requires plans to provide the greater of (1) one drug in each category and class of drugs; or (2) the number of drugs in each such category and class of the benchmark plan. For habilitative services (those services related to learning new skills or functions — as distinguished from rehabilitation which focuses on relearning existing skills or functions), the proposal provides additional flexibility. Where a state has not defined required habilitative benefits, it

[1] "Essential Health Benefits Bulletin," December 16, 2011 http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. "Actuarial Value and Cost-Sharing Reductions Bulletin," February 24, 2012 http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf. "Frequently Asked Questions on the Essential Health Benefits Bulletin", February 17, 2012 http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

permits issuers to meet the EHB for habilitative services by providing services in their plans that are on par with those offered for rehabilitative services or by submitting a proposal for habilitative coverage to CMS for review.

In the area of actuarial value (AV), the proposed rule hews closely to the Bulletin, including in its adoption of the standard for allowable variation of plans from the "metal" levels of plus or minus two percent. Importantly, CMS also released its promised AV calculator that will allow issuers and exchanges to determine the percentage of health plan costs covered in order to determine the metal level of the plan.

In addition, the proposed rule and a final notice, also issued on November 20, describe the accreditation of QHP issuers. The final notice on accreditation formally recognizes the National Committee for Quality Assurance (NCQA) and URAC as accrediting entities for the purposes of "phase one" QHP certification (defined as the first two years of exchange operations — 2014 and 2015). The proposed rule (1) would allow additional organizations to apply to be recognized as accrediting entities for phase one; and (2) provides a timeline for meeting accreditation requirements for federal exchanges, including state partnership exchanges.

Until the proposed rule is published in the Federal Register, you may find it at
http://www.ofr.gov/OFRUpload/OFRData/2012-28362_PI.pdf

Key Provisions

Essential Health Benefits

Benchmark Plan Selection

The proposed rule incorporates the process for state selection of a benchmark plan that was first announced in the EHB Bulletin. States will select what is now referred to as the "base-benchmark plan" from among ten choices. For states that have already made a selection, the preamble to the proposal provides that they will have until comments are due on the proposal (December 26) to change their selection. States that have not made a selection will also have until that date to make their base-benchmark plan selection. As in the Bulletin, states that do not make a selection will default to the largest plan by enrollment in the largest product in the state's small group market.

For multistate plans, the proposed rule provides that they will have to meet benchmark standards set by the U.S. Office of Personnel Management (OPM). This postpones a decision on how EHBs will be administered in these plans. If OPM requires plans to provide state-specific EHBs in each state, the plans will not have the uniformity across states that was anticipated by the ACA. If they are allowed to have a single set of EHBs across states that differs from other plans offered within state exchanges, it could create issues in risk selection as individuals might choose plans based on the different benefits they provide and could undermine the goal of having consumers be able to make easy comparisons among exchange plans with similar benefit packages.

Benchmark Plan Supplements

As in the Bulletin, the proposed rule creates a process for states (or HHS in states not choosing a benchmark plan) to supplement the base-benchmark plan for any of the ten required EHB categories the base-benchmark may lack. States may select needed supplemental benefits from any one of the other plans that they did not select as a base-benchmark. For the default states, HHS will search for the missing benefits within, in order, the largest plan by enrollment in the second-largest product in the state's small group market, then the third-largest, and then the largest FEHBP plan.

The proposed rule contains special requirements for pediatric oral care and pediatric vision benefits. For pediatric oral care, if the base-benchmark lacks this category, states may add it from either the Federal Employees Dental and Vision Insurance Plan (FEDVIP) dental plan with the largest national enrollment or

the state's CHIP plan. For pediatric vision, if the base-benchmark lacks this category, states may add it from either the FEDVIP vision plan with the largest national enrollment or the state's CHIP plan. This last option for pediatric vision to use the CHIP plan is an addition from what was described in the Bulletin. Where the state has defaulted to a base-benchmark plan, the pediatric vision benefits are added, if needed, from the FEDVIP vision plan with the largest national enrollment and the pediatric oral care benefits are added, if needed, from the FEDVIP dental plan with the largest national enrollment.

Another area of intense interest is habilitative services, which could include coverage for autism therapy. The proposed rule gives states authority to determine the habilitative benefits that plans must include. Where the state has defaulted or has not defined the habilitative benefits, the proposed rule provides that an issuer will satisfy the requirement that its plan offer habilitative services either by including benefits that are "similar in scope, amount, and duration to benefits covered for rehabilitative services or by making its own determination of what habilitative benefits it will cover and reporting its determination to HHS."

In the Bulletin, HHS had suggested that it might consider one or the other of these options. In the proposed rule, it is offering the choice to the issuers themselves. This flexibility could have a major impact on beneficiaries in states that do not have defined habilitative benefits through state benefit mandates or other means.

Benefit Substitution

The proposed rule clarifies open issues from the Bulletin about the ability of issuers to substitute a benefit not offered in the base-benchmark plan for one that is provided. As provided in the Bulletin, the proposed rule would allow issuers to make actuarial equivalent substitutions within an EHB category. However, the proposed rule makes clear that issuers may not make such substitutions among categories. Also, issuers may not make substitutions within the drug benefit category.

Prescription Drugs

Drug benefits differ from other benefits in their use of formularies, or lists of covered medications. The scope of covered drugs is an important element of a drug benefit. In the Bulletin, HHS had articulated special rules for drugs, providing that plans had to include at least one drug in every category and class (a subunit of categories) of drugs and suggesting possible lists of such categories and classes. This standard generated significant controversy, since most health plans today have many more than one drug in each category and class.

In response to comments on the Bulletin, the proposed rule provides a new standard. In order to satisfy the EHB requirement, each plan would be required to include the greater of: (1) one drug in each category and class; or, (2) the number of drugs in each category and class in the base-benchmark plan. Thus, if a base-benchmark plan has none or one drug in a class, the EHB requirement is one drug in that class. If the base-benchmark has two or more drugs in a class, the EHB requirement is to have at least that many drugs. The proposed rule requires issuers to submit their lists of covered drugs to the exchange, state, or OPM, as appropriate.

The proposed rule also clarifies that the list of categories and classes will come from the United States Pharmacopeial Convention (USP) Medicare Part D Model Guidelines Version 5.0, which was released in 2011.[2] The proposed rule promises that HHS will continue to "assess the need for and value of such a tool and intend to work with states and the NAIC to facilitate state use of the USP classification system as a comparison tool."

In addition to the above, the proposed rule would require issuers to have procedures to allow enrollees to "request clinically appropriate drugs not covered by the health plan." However, the proposed rule does not specify what conditions plans may establish for considering such requests or standards for when a plan must honor them.

[2] http://www.usp.org/sites/default/files/usp_pdf/EN/healthcareProfessionals/2011-03-11uspmgcatclass.pdf

Nondiscrimination

The proposed rule states that a plan would not be considered to provide EHBs if its benefits discriminate based on age, expected length of life, disability, medical dependency, quality of life or other health conditions. It does not, however, provide any guidance on how such possible discrimination would be determined or by whom. The proposal seeks comments on approaches to ensure that the EHB-benchmark plans do not include discriminatory benefit designs and do reflect an appropriate balance among the categories of EHBs. In comments made in connection with the release of the proposed rule, HHS officials suggested that they would issue sub-regulatory guidance in the future to define standards for discriminatory benefit design review.

For drugs, the preamble to the proposed rule states that HHS will "encourage states to monitor and identify discriminatory benefit designs, or the implementation thereof and to test for such discriminatory prescription drug benefit designs. We will use information on complaints and appeals and data on drug lists to refine our prescription drug benefit review policy for future years."

Other Benefit Rules

The proposed rule provides that non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and cosmetic orthodontia may not be considered EHBs. This appears to mean that, to the extent that a state requires such benefits, the state would have to pay the entire costs of such benefits as it would with any state mandate that is not an EHB.

Payment for State-Required Benefits Beyond EHBs

The ACA requires that, to the extent a state requires benefits within QHPs that are not EHBs, the state must assume the full cost of providing such benefits either in the form of payments directly to plan participants or to issuers on behalf of its participants. States may avoid the payment requirement to the extent that the benchmark plan (as selected or as determined by default) contains state required benefits enacted on or before December 31, 2011, since those benefits would be considered EHBs.

The proposed rule clarifies that state required benefits are those involving care, treatment, and services and do not include those related to provider types, cost sharing or reimbursement methods. Thus, even though these state law requirements may impose cost on plans, the state does not have to pay for them.

When a state does have to make payments, the proposed rule provides that the issuer of the QHP itself would calculate the cost of the state-required benefits that are not EHBs. HHS has asked for comments on whether the payments should be based on the statewide average cost of the state-required benefit or on the actual cost of the QHP delivering the benefits.

Description of Proposed Benchmarks

The proposed rule contains a table that describes the status, as of November 20, of state selection of (or default to) EHB base-benchmarks and the supplements to those base-benchmarks. In addition, the proposed rule includes a reference to Web content that describes, in detail, each state's benchmarks including the number of drugs in each category and class. That content can be found at http://cciio.cms.gov/resources/data/ehb.html.

Actuarial Value

AV Calculator

As originally described in the Actuarial Value and Cost-Sharing Reductions Bulletin, the proposed rule incorporates by reference the use of an actuarial value (AV) calculator that is found at http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsm.

Issuers will enter the cost sharing parameters of their plan benefit design into the calculator to determine if the offering meets the requirements of the metal levels' AV. The calculator has the capacity to calculate AV

based on a set of standard parameters such as deductibles, out-of-pocket limits and coinsurance for services such as physician visits. It also has the ability to calculate the impact of a limited range of plan cost sharing variations such as the waiver of cost sharing following a set number of provider visits. For drugs, it uses the cost sharing for generics, preferred brands, non-preferred brands, and specialty drugs.

Because the calculator is not designed to calculate the AV of non-standard plan designs (with nonstandard cost sharing variations), the proposed rule would allow plans to determine their AV through alternative means, specifically by permitting plans to have an actuary make adjustments in the cost sharing design solely for the purpose of fitting the design into the calculator. Alternatively, the proposed rule would allow an actuary to use only those design elements that fit into the calculator and then adjust the resulting AV to account for the non-standard designs.

The AV calculator uses a national data set to determine the AV of plan designs. Recognizing that this approach may not provide the most accurate results across the country, the proposed rule would, starting in 2015, allow states to substitute their own data into the calculator subject to standards set out in the proposal and also subject to HHS review and approval.

Metal Levels

The proposed rule restates the ACA's AV levels required for each of the metal levels — 60 percent for bronze, 70 percent for silver, 80 percent for gold, and 90 percent for platinum.

Recognizing that the calculator can only provide an imperfect estimate of a plan's AV, the Bulletin suggested that HHS would allow small variations, plus or minus two percent, in AV around the metal level requirements. The proposed rule adopts this standard. Thus, if the AV calculator provides a result that a plan has an AV of 58 percent, the plan would still qualify as a bronze plan that requires a 60 percent AV.

Minimum Value

Starting in 2014, sponsors of employer-provided health plans will need to determine whether they provide minimum value, which is defined as the employer paying 60 percent of the allowed cost of plan benefits. Providing minimum value is important for determining eligibility for the premium tax credits and for determining if an employer must make a shared responsibility payment. The proposed rule announces that HHS and the Internal Revenue Service (IRS) will be making available a calculator for the use of employers in determining if they are providing minimum value. As alternatives to using the calculator, the employer may also benefit from safe harbors to be announced by the IRS or use an actuary to adjust the result of the calculator as appropriate.

Cost Sharing Requirements

In addition to restating the required limits on annual cost sharing, the proposed rule addresses an issue raised in connection with the deductible limits for small group plans. The ACA provides that the deductible for such plans may not exceed $2,000 for self-only coverage or $4,000 for other than self-only (e.g., family). However, because, in some cases, it might not be possible to design small group plans that maintain this limit and also achieve the 60 percent AV of a bronze plan, the proposed rule would allow plans that exceed the deductible limit when necessary to achieve the required AV.

Accreditation

There are two provisions of note in the proposed rule with respect to QHP accreditation. Previously, HHS had determined that only NCQA and URAC were eligible accreditation entities for phase one, and it deferred accreditation of phase two entities, which would involve a criteria-based review process, to future rulemaking.[3] HHS now proposes to open up the phase one process to allow additional organizations to qualify as accreditation entities. The expansion of the phase one recognition process for accrediting organizations would increase choices regarding QHP accreditation for exchanges, states and issuers. This should help increase competition among accreditation entities beyond NCQA and URAC and provide broader accreditation capacity in phase one of exchange operations.

[3] 77 Fed. Reg. 42658, July 20, 2012

The second key provision addresses QHP accreditation in federal exchanges (including state partnership exchanges) where HHS is proposing to accept existing accreditation by an accreditation entity on an issuer's commercial or Medicaid lines of business until the fourth year of certification (e.g., 2016 certification for the 2017 year). The timeline proposed recognizes the significant time that issuers will need to obtain accreditation. The rules also address the accreditation time frames for QHPs that do not have existing accreditation. Specifically, the proposed rule requires QHP issuers that are not accredited to (1) schedule the accreditation review in their first year of certification of the QHP (e.g., 2013); (2) be accredited on their QHP policies and procedures in their second and third years of certification (e.g., 2014 and 2015); and (3) by the fourth year of certification of the QHP (e.g., 2016 certification for the 2017 coverage year), be accredited on the basis of local performance of the QHP.

Conclusion

The proposed rule, while breaking little new ground, provides important information that is needed for the implementation of the ACA's insurance rules and health insurance exchanges in 2014. Because so much of the content of the proposed rule was previewed in previously issued guidance that was subject to public comment, it is reasonable to anticipate that much of the proposed rule will become final in its current form early in the new year. Therefore, it is likely that participants in ACA planning will be able to rely on the content of the proposed rule in their work. In terms of providing comments on the proposed rule, while all of it is subject to change through the public comment process, it should be most effective to comment on content that is new in the proposed rule and content for which HHS has specifically asked for input.

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