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HHS Issues Comprehensive "Essential Health Benefits" Proposed Regulations

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Commencing in 2014, the Patient Protection and Affordable Care Act (Act) requires that health insurance coverage provided in the individual and small group markets, including coverage offered through American Health Benefit Exchanges (or, simply "exchanges"), provide "essential health benefits." This requirement is part of a larger regulatory scheme that includes:

- A requirement that all U.S. citizens age 18 and over maintain health insurance coverage;
- Premium support (in the form of advanceable, refundable tax credits and cost-sharing subsidies) to help low- and moderate-income individuals afford coverage and pay for benefits; and
- Obligations on large employers (i.e., those with 50 or more full-time equivalent employees) that penalize the failure to offer comprehensive, affordable coverage to full-time employees (this requirement is referred to as "employer shared responsibility").

Exchanges are publicly available, online marketplaces through which individuals and small groups can purchase health insurance coverage under plans that are "affordable" as defined by the Act. In addition to providing essential health benefits (EHB), these plans, as well as Medicaid benchmark plans, must offer four levels of actuarial value: 60% (bronze), 70% (silver), 80% (gold), and 90% (platinum). These actuarial value levels are referred to as "metal levels." Actuarial value is an estimate of the overall financial protection provided by a health plan. A plan's actuarial value describes the portion of covered medical expenditures that a plan is likely to pay across a "typical" or "standard" covered population. For example, an actuarial value of 70% means that on average the health plan is expected to pay 70% of covered medical expenses across its standard population. The remaining 30% is paid by participants and beneficiaries through copays, deductibles, coinsurance, and other cost-sharing features. Various combinations of deductibles, coinsurance, and out-of pocket limits can produce the same actuarial value. Policies with these various metal levels that satisfy other cost-sharing requirements are said to provide an "essential health benefits package." Plans that provide an essential health benefits package and are properly accredited and certified are referred to as "qualified health plans" (QHPs).

The extent to which employees can qualify for subsidized coverage under an exchange affects an employer's exposure under the Act's employer shared responsibility standards. What constitutes actuarial value also has important parallels affecting employers. (Employer plans, for example, must offer "minimum value" — which is analogous to actuarial value for EHB purposes — in order to avoid the imposition of an assessment.) Thus, while ostensibly aimed at state-licensed carriers issuing health insurance in the individual and small group markets, what constitutes EHB is of interest as well to large employers.

EHB Background

Essential health benefits 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, and (10) pediatric services, including oral and vision care. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to provide essential health benefits. Self-insured, large fully insured, and grandfathered plans will, however, be affected by the rules governing EHBs since these plans are prohibited from imposing lifetime limits and annual dollar limits on essential health benefits.

The Act requires that essential health benefits be modeled on "a typical employer plan," with respect to which HHS must strike "an appropriate balance among the benefit categories." Benefits must not, however, discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population. Congress directed the Department of Health and Human Services (HHS) to issue regulations implementing the essential health benefits requirement.

On December 16, 2011, HHS issued a bulletin (the Bulletin) that proposes granting the states significant flexibility to establish what constitutes essential health benefits in their states. The Bulletin addressed covered items and services, but it did not address cost sharing or the calculation of actuarial value, which was addressed in other guidance.

The Proposed EHB Regulation

On November 26, 2012, HHS issued a comprehensive proposed regulation that builds on the proposals first advanced in the Bulletin. The proposed regulations establish a framework for essential health benefits and actuarial value. The proposed regulations also include standards for health insurance issuers in the small group and individual markets related to health insurance reforms, standards for states relative to the establishment of Exchanges, and standards for issuers of Qualified Health Plans relating to participation in an Exchange.

The preamble to the proposed regulation reiterates HHS's intended regulatory approach, starting with currently available employer-sponsored coverage as a benchmark, but supplementing that coverage as necessary to ensure that plans cover each of the 10 statutory categories of essential health benefits. Specifically, HHS said that its goal is to pursue an approach that will:

- Encompass the 10 categories of services identified in the statute;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure there are no incentives for coverage decisions, cost sharing, or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Provide states a role in defining essential health benefits; and
- Balance comprehensiveness and affordability for those purchasing coverage.

Benchmark Plans

The proposed regulation permits each state to designate what constitutes essential health benefits from among the following four benchmark plan types:

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.

If a state does not exercise the option to select a benchmark health plan, HHS proposes that the default benchmark plan for that state would be the largest plan by enrollment in the largest product in the state's small group market.

If a category of benefit is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer essential health benefits. Thus, in selecting a benchmark plan, a state may need to supplement the benchmark plan to cover each of the 10 essential health benefit categories listed above. (The most commonly noncovered categories of benefits among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services.) If a benchmark is missing other categories of benefits, the state must supplement the missing categories using the benefits from any other benchmark option. In a state with a default benchmark with missing categories, the benchmark plan would be supplemented using the largest plan in the benchmark type by enrollment offering the benefit. If none of the options in that benchmark plan offer the benefit, the benefit will be supplemented using the FEHBP with the largest enrollment. An appendix to the proposed regulation lists proposed EHB-benchmark plans, as well as the default benchmark plan for each state that does not select a benchmark plan.

State-mandated benefits can often go above and beyond the federal standards. The Act requires states to defray the costs of state-mandated benefits in excess of essential health benefits for individuals enrolled in any qualified health plan. In previous guidance, HHS proposed a transition period for states to coordinate their benefit mandates. The proposed regulations offer a more favorable rule under which state mandates in effect as of December 31, 2011 are deemed to be essential health benefits that are not subject to a separate surcharge at least for the 2014 and 2015 benefit years."

Actuarial Value

Beginning in 2014, nongrandfathered health plans in the individual and small group markets must meet certain actuarial values described above. The proposed regulations reflect these standards, and they provide that a plan can meet a particular metal level if its actuarial value is within 2 percentage points of the standard, e.g., a silver-level plan may have an actuarial value between 68% and 72%. Carriers are also permitted to offer catastrophic-only coverage with a lower actuarial value to younger individuals and to individuals for whom coverage is deemed "unaffordable."

To assist with actuarial value calculations, HHS is making available to the public an actuarial value calculator that carriers can use to determine actuarial value. Consistent with the requirements of the Act, the calculator will be based on a national, standard population. HHS is considering whether to accept state-specific data sets for the standard population if states choose to submit alternate data for the calculator. The proposed rule includes alternative rules for the determination of actuarial value for plans with benefit designs that the calculator cannot easily accommodate. These alternatives are based on individual determinations certified by a duly licensed actuary.

Accreditation Standards

The Act encourages but does not require states to establish insurance exchanges. In states that decline to do so, HHS will establish and operate a "Federally-facilitated Exchange." Alternatively, states can choose to take on some but not all of the obligations of a state-based exchange under an arrangement referred to as a "State Partnership Exchanges." Under either approach, exchanges will offer only accredited QHPs.

The proposed regulation establishes accreditation standards for QHPs, and it initially designates two accreditation agencies—i.e., the National Committee for Quality Assurance and URAC (f/n/a the "Utilization Review Accreditation Commission"). Additional accrediting entities are allowed to apply to HHS to be recognized as accrediting entities.

Coordination with Annual and Lifetime Limits

What constitutes EHB is of concern to large employers in connection with the implementation of certain other of the Act's requirements prohibiting lifetime and annual limits. Under the Act, group health plans may not establish

any lifetime or annual limits on the dollar value of benefits for any individual under the group health plan. To this general rule, there are two exceptions. First, a group health plan may impose lifetime or annual limits on the dollar value of specific covered benefits that are not "essential health benefits," and, second, for plan years beginning before January 1, 2014, a group health plan may impose "restricted" annual limits on essential health benefits.[1]

In a set of questions and answers issued in February 2012,[2] the Centers for Medicare & Medicaid Services appears to say that self-funded and insured plans in the large group market are free to choose their own benchmark plan, which will determine which particular benefits under the employer's plan are or are not EHBs.[3] The benchmark plan must be one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all 10 statutory categories). Thus, for example, an employer would likely be permitted to use the benchmark plan of the state of the employer's domicile. The proposed regulation does not address the issue.

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Endnotes

1 Act § 1001, adding Public Health Service Act § 2711.

2 http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf

3 Id., Q&A 10.

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