Final Rule on Essential Health Benefits, Actuarial Value, Accreditation

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Prepared by ACP's Health Policy and Regulatory Affairs Department

On February 20, 2013, the Department of Health and Human Services released the final rule regarding essential health benefits, actuarial value and accreditation established in the Affordable Care Act (ACA). The ACA requires that all non-grandfathered individual and small group plans offered through the health insurance exchange (qualified health plans or QHP) or outside of the exchange must provide the essential health benefit package, and cover 10 categories of health benefits equal in scope to the typical employer plan, limit cost-sharing, and meet actuarial value standards. The 10 EHB coverage categories are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (incl. behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services (including oral and vision care).

The final rule largely reflects the approach outlined in the 2011 EHB Bulletin and the proposed rule. In 2014 and 2015, each state will choose a base-benchmark plan to which EHB packages must be substantially equal. States may choose the largest plan by enrollment in any of the 3 largest small group plans in the state, any of the largest 3 state employee health benefit plans, any of the largest 3 Federal Employees Health Benefits Program plans, or the largest insured non-Medicaid HMO in the state. The default for plans that do not select a base-benchmark plan will be the largest plan by enrollment in the largest product in the small group market. If a base-benchmark plan does not cover a category, it must supplement by adding the entire category of benefits offered by another base-benchmark plan option.

Although the final rule generally reflects ACP policy, there may be opportunities for the College and its chapters to advocate for a stronger EHB requirement.

- Push state insurance regulators to provide strong oversight of insurers who intend to substitute a benefit within the same essential health benefit category. Oversight is needed to ensure health coverage meets the definition of EHB package, including the requirement that plans reflect the typical employer plan, and that necessary care is included and not substituted in favor of cheaper, less comprehensive benefits and services.
- Support strong oversight of the prohibition on discrimination, which states an insurer's benefit design may not discriminate based on an individual's age, expected length of life, present or predicted disability, quality of life, etc.
- Advocate for states to require that out-of-network cost-sharing expenses count toward the annual limitation on cost-sharing and deductibles.
- Push states to select base-benchmark plans with comprehensive preventive and wellness care and chronic disease management services and supports. The base-benchmark plan should cover comprehensive prescription drug benefits (e.g. greater than the one drug in each USP category/class).
- Request that states support the consideration of clinical and cost-effectiveness in determining the benefit package. ACP policy supports the expansion of value-based health insurance, where use

of evidence-based, high-quality services and products is encouraged. This is especially important if plans intend to substitute benefits within categories.

The following side-by-side comparison provides ACP's comments regarding the EHB proposed rule and relevant discussion from the final rule.

Final Rule Language	**ACP Comments**
156.115 Provision of EHB Based on the rationale we outlined in the proposed rule, we are maintaining the substantially equal standard as written to allow for flexibility of plan design. We confirm that plans must comply w/ mental health parity standards in individual and small group markets to satisfy EHB req. States will not have to defray such costs. Comment: Many commentators urged HHS to eliminate the option to substitute benefits, noting concerns that substitution may result in discrimination. Commentators also requested that HHS codify the implied option for states to limit or completely prohibit substitution. Response: We retain discretion proposed to provide substitution within categories to provide greater choice to consumers, and promote plan innovation through coverage and design options. We also retained requirement that any substitution must be actuarially equivalent. As the party responsible for enforcement of EHB, it is up to each state to set criteria for substitution in its state consistent with [parameters set in rule]	The proposed rule establishes that health insurance issuers will have flexibility to determine benefit packages providing they are "substantially equal" to the base-benchmark plan chosen by the State. The College is concerned that without strong oversight of insurance issuer practices, insurers may substitute benefits they deem too expensive or preferred by sicker patients, in favor of less costly services or products. Further scrutiny must be applied to protect against risk segmentation if benefit packages are tailored in a way that attracts a disproportionate share of healthy, low-cost enrollees. HHS should consider only permitting substitutions if the procedure or service to be replaced is proven to be of limited clinical effectiveness or low value. Independent actuaries should be required to perform rigorous audits on insurance plans to determine whether the plans cover all services in the 10 benefit categories, include benefits that are substantially equal to the benchmark plan, and are at least actuarially equivalent to the benchmark plan. ***Staff Comment:*** Language on benefit substitution within categories remains. HHS has included safeguards – including review of substituted benefits by an actuary to ensure actuarial equivalence – but state regulators should provide strong enforcement to ensure insurers aren't developing packages that may discriminate vulnerable, complex-need patients. ACP supports the mental health parity law, and this rule clarifies that mental health parity must be provided in EHB packages.
156.120 Prescription Drug Benefits	ACP also recommends caution on permitting substitutions among prescription drug categories,

We have added language from the proposed rule preamble to §156.122(c) directing plans to have procedures to allow an enrollees to gain access to clinically appropriate drugs	especially if it creates restrictive formularies primarily geared towards cost control rather than high-value, cost-conscious care. Decisions about which drugs are chosen for formulary inclusion should be based upon the drug's effectiveness, safety, and ease of administration rather than solely based on cost. Comment: The final rule is an improvement over previous iterations that mandated one drug per class. Now EHB would have to meet the greater of 1 drug/class or the same number of drugs in category /class of EHB-benchmark, which could be a higher number. The rule also establishes an appeals process and ACP will have to monitor to ensure expedited decision-making process and enforcement of appeals. Many consumer advocates and AMA had called for plans to meet the stronger Medicare Part D standard (i.e. all or substantially all drugs w/in category/class), but the final rule does not reflect that request. ACP policy does not recommend a specific standard, but expresses concern about tight formularies that may restrict access to necessary drugs. The prohibition on discrimination in the rule is designed to ensure that plans don't design benefits that favor or harm a certain category of beneficiary.
<u>156.125 Prohibition on discrimination</u> - Several commenters expressed concern that enrollees with certain health conditions might by discriminated against by an issuer's failure to include appropriate specialists in their network. Enforcement of the PHS Act provisions codified in this rule is governed by section 2723 of the PHS Act, which first looks to states and then to the Secretary when a state does not substantially enforce. The approach to nondiscrimination will reserve flexibility for both HHS and the states to respond to new developments in benefit structure and implementation and to be responsive to varying circumstances across the states. We agree with the commenters that network adequacy is an important part of plan coverage. Compliance with network adequacy requirements is outside of the scope of this regulation. - Some commenters expressed concern that	In designing an essential benefit package and/or selecting a benchmark plan, stakeholders across the health care spectrum – particularly patients and physicians and other health care providers – must be consulted. ACP strongly believes that the public, patients, physicians, insurers, payers, and other stakeholders should have opportunities to provide input to health resource allocation decision-making at the policy level.**Error! Bookmark not defined.** This is particularly important if insurers are permitted to substitute services within benefit categories as proposed by the rule. Evaluation of health plan benefit packages must be ongoing to determine its impact on access to physicians and other health care professionals, the promotion of preventive health and high value care, and the effect on racial and ethnic health disparities, among other factors. *Staff Comment:* the discrimination rule remains fairly strong, although there is no discussion about enforcement. The limits on medical management ensure that such action reflect national standards for care.

the anti-discrimination provision would prevent medical management. An Issuer could use prior authorization, but could not implement prior authorization in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence-based. (e.g. prior authorization for shingles vaccine required for under age 60, based on immunization standards) We add language to clarify that nothing in this section shall be construed to prevent an issuer from using reasonable medical management techniques	
<u>156.110 EHB-benchmark plan standards</u> The statute directed the Secretary to define EHB to include at least the 10 identified categories, while ensuring that the scope of EHB is equal to the scope of benefits provided under a typical employer plan. However, typical employer plans differ by state. The Secretary balanced these directives, and minimized market disruption, by directing plans to offer the 10 statutory EHB categories while allowing the state to select the specific details of their EHB coverage by reference to one of a range of popularly selected plans offered in the state or as part of the FEHBP. Accordingly, the states continue to maintain their traditional role in defining the scope of insurance benefits and may exercise that authority by selecting a plan that reflects the benefit priorities of that state.	Future guidance should clarify what services must be covered under the preventive and wellness services and chronic disease management category, as such interventions are crucial in the drive to prevent and manage chronic disease. States must be encouraged to select benchmark plans that provide a comprehensive menu of preventive and primary care services that will help stave the growth of chronic illness and foster wellness. The Affordable Care Act has been instrumental in enhancing access to preventive services approved by the United States Preventive Services Task Force by requiring coverage of such benefits without cost-sharing. This focus on primary care should be continued in development of the essential health benefit package. ACP appreciates that the proposed rule affirms that preventive services without cost-sharing are to be included in EHB benchmark plans and that annual deductibles do not apply to preventive services. *Staff Comment*: Final rule maintains that state will decide base-benchmark on which QHP benefits will be based. ACP chapters may want to advocate states to choose base-benchmark plans w/ comprehensive preventive/wellness services.
No relevant provision.	HHS charged the Institute of Medicine (IOM) with creating a framework designed to help the agency define benefits and update benefit packages to

	reflect the latest science, access issues, and effects on cost. While IOM did not provide any recommendation on specific services that should be included in the essential health benefits (EHB) package, it did make a number of recommendations that reflect ACP policy and could potentially facilitate the evolution of the essential benefit package to one that would provide high-value, evidence-based services. Of notable interest to ACP, the recommendations support the consideration of clinical and cost-effectiveness in determining the benefit package. ACP policy supports the expansion of value-based health insurance, where use of evidence-based, high-quality services and products is encouraged. Specifically, ACP policy states that, "employers and health plans should consider adopting value-based benefit design programs that use comparative research on clinical outcomes and cost effectiveness developed by an independent entity that does not have an economic interest in the benefit determinations."[i]
156.130 Cost-sharing requirements Cost-sharing requirements are applicable to non-grandfathered health insurance coverage offered by health insurance issuers in the individual and small group market, and qualified health plans. - Annual limits on cost-sharing apply to qualified health plans, all group plans, including self-insured and large group plans. Annual limits on cost-sharing based on those of high-deductible health plans (i.e. in 2013 the cap is $6,250 for self only and $12,500 for non-self-only). - Annual limits on deductibles for small group market QHPs In 2014, deductibles will be $2000 for self, $4000 for non-self coverage. Bans prior authorization for Out-network emergency care and establishes cost-sharing parity for in-network and out-network emergency care. Comment: HHS received several comments suggesting a standard definition of the reasonableness exemption in proposed	Although the cost-sharing limitations proposed in the rule generally reflect ACP policy, the College is concerned that small group health plans may be relieved of the annual deductible limit requirement if they can prove they "may not reasonably reach the actuarial value of a given level of coverage…without exceeding the annual deductible limit." The College acknowledges that providing cost-sharing flexibility to health plans may encourage market participation and lead to a wider choice of health plans for consumers. Deductibles can also be a useful tool in limiting overuse of services and encouraging use of evidence-based, high value procedures. However, the College cautions that relieving health plans of their obligation to limit cost-sharing may permit plans to impose high deductibles that are unaffordable to low-income individuals and cause patients to forego treatment because of cost. The College recommends that if small group health plans are permitted to increase annual deductibles, that this exception be implemented sparingly and that such flexibility be temporary and phased out over time. ACP is also concerned that the proposed rule may undermine access to and affordability of physicians

§156.130(b)(3) for plans in the small group market that can only meet the deductible requirements as well as certain actuarial value requirements such as for a bronze plan for a very narrow range of plan designs. Response: We intend to provide sub-regulatory guidance outlining options related to plan designs where exceeding the deductible limits described in §156.130(b) is permissible. We reiterate that §156.130(b) as finalized here applies only for purposes of defining a cost-sharing CMS-9980-F 58 limitation application to issuers and QHPs that must offer the EHB package. Comment: HHS received several comments discussing the merits of applying the cost-sharing limits to in-network services only rather than applying the annual cost sharing limits defined in §156.130(a) to all costs including both in-network and out-of-network fees. Response: Our research has shown that generally, health spending occurs in-network. The IOM in its recommendation focused on the long term balance between affordability and comprehensiveness of coverage, therefore, we have decided to apply cost-sharing limits to in-network visits only to promote health plan affordability. We note that nothing in this proposal explicitly prohibits an issuer from voluntarily establishing a maximum out-of-pocket limit applicable to out-of-network services, or a state from requiring that issuers do so. *Comment:* Several commenters expressed concerns about the protection of a health plan's ability to control costs through the use of reasonable medical management, as well as cost and administrative burdens placed on QHP issuers. *Response:* We do not believe that the requirements pertaining to cost-sharing would preclude issuers from engaging in reasonable medical management. However, in response to comments about the protection of a health plan's ability to control costs through the use of utilization management and administrative burden, we are not finalizing the policy as paragraph (g) of § 156.130 [prohibition of	not included in a plan's provider network. Under the proposed rule, out-of-pocket costs for care provided by an out-of-network physician would not count toward the annual cost-sharing limit or the annual limit on deductibles. To ensure that patients do not face an undue financial burden for receiving vital care, the College requests that at a minimum, cost-sharing restrictions apply to out-of-network care received when appropriate physicians (i.e. subspecialists) or services are not offered in the plan's existing network. *Staff Comment:* Chapter should urge state regulators to apply cost-sharing limits/deductible caps on out-of-pocket expenses for out-of-network care. The final rule removes the prohibition on discriminatory cost-sharing to address concerns that this would interfere with reasonable medical management. The final rule codifies a general prohibition on discriminatory EHB benefit structure, that would presumably still cover cost-sharing. However, there is no discussion in the rule of enforcement of anti-discrimination rules. Presumably, this would fall on the state, so chapters should push state regulators to ensure that plans abide by anti-discriminatory provisions. Note, however, that plans will have to abide by network adequacy standards that may reduce the need for out-of-network coverage assuming plan networks include adequate access to necessary providers. An HHS FAQ document states that additional rulemaking regarding the cap on deductibles for large group and self-insured plans is forthcoming. **NOTE:** An FAQ released by HHS on February 20, 2013 clarifies that if a plan does not have any in-network providers to provide a particular preventive service required by ACA (e.g. preventive services w/ USPSTF "A" or "B" rating or immunizations recommended by Advisory Committee on Immunization Practices), then the plan cannot impose cost-sharing for preventive services provided out-of-network. The FAQ states, "if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service."

discriminatory cost sharing] and we are relabeling the remainder of § 156.130 accordingly.	
156.135: AV calculation for determining level of coverage: describes how the actuarial value will be calculated. Generally, it is based on a standard population (which can be state-specific in 2015). Calculation will be done by HHS's AV Calculator.	ACP did not comment on this provision.
156.140: Level of coverage. Defines metal-tier coverage, e.g., bronze coverage must have an actuarial value of 60%.	ACP did not comment on this provision.
156.145: Determination of minimum value: HHS has developed a calculator to determine whether a plan meets the minimum value requirement (60% AV). If plans do not meet this definition of comprehensiveness, they will have to pay a penalty if their employees receive a tax credit to buy exchange-based care.	ACP did not comment on this provision.
156.275: Recognition of Accrediting Entity by HHS. Sets timeframe for accreditation of plans. Recognized accrediting organizations are NCQA and URAC, but HHS will consider other applicants.	ACP did not comment on this provision.

[i] American College of Physicians. Controlling Health Care Costs While Promoting The Best Possible Outcomes. Philadelphia: American College of Physicians; 2009: Policy Monograph.