Essential Health Benefits & Actuarial Value

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS for MEDICARE & MEDICAID SERVICES
Center for Consumer Information and Insurance Oversight

Health Insurance Exchange System-Wide Meeting
May 21-23, 2012

Agenda

- Essential Health Benefits (EHB) Benchmark Selection
  - Policy Overview
  - Selection Process
- Actuarial Value (AV)
  - AV Bulletin
  - AV Calculator User Experience

Background on Essential Health Benefits (EHB)

- The Affordable Care Act tasks the Secretary with defining essential health benefits (EHB)
- The Affordable Care Act identifies ten categories of items and services that must be included in the definition of EHB. EHB must:
  - Be equal to the scope of benefits covered under a typical employer plan
  - Consider balance, discrimination, and the health care needs of diverse segments of the population
- The following plans must cover EHB :
  - Non-grandfathered health insurance plans in the individual and small group markets both inside and outside of the Exchanges
  - Medicaid benchmark and benchmark-equivalent and Basic Health Programs

EHB Categories

- Ambulatory patient services
- Emergency Services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including 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

Benchmark Approach

- EHB defined by a benchmark plan selected by each State
- Department aims to balance comprehensiveness, affordability, and State flexibility as well as take into account public input received to date
  - Bulletin on intended regulatory approach to defining EHB released December 16, 2011
  - Illustrative list of largest small group products released January 25, 2012
  - Frequently Asked Questions on Bulletin released February 17, 2012

  These documents are available at http://cciio.cms.gov

Benchmark Type Options

- One of the three largest small group plans
- One of the three largest State employee plans
- One of the three largest Federal employee plans
- The largest HMO plan offered in the State's commercial market

Defining the Benchmark EHBs

- Plans that cover EHB must provide coverage for all 10 statutory categories
- If a benchmark is lacking a statutory category, it must be supplemented from another benchmark option
- Mental Health and Substance Abuse parity applies in the definition of EHB

State Choice of Benchmark

- State selects a single benchmark for 2014 and 2015, which will define the set of benefits (including limits) all applicable plans must provide
- If a State does not exercise the option to select a benchmark health plan, the default benchmark plan for that State would be the largest small group plan by enrollment

Process for Benchmark Selection

- The benchmark options will be based on enrollment as of March 31, 2012
- States must select a benchmark and supplement that benchmark as necessary by the third quarter of 2012, or the default benchmark will apply

State Benefit Laws

- State laws requiring coverage of benefits (i.e., mandates) enacted before December 31, 2011, and applicable to the benchmark plan will be considered part of EHB
- States will be required to defray the cost of any State mandates not included in the selected benchmark plan
- This approach to State mandates is intended to be a two year transitional approach for 2014 and 2015, at which point we intend to revisit the approach

Habilitative Services

Because habilitative services are a less well defined area of care, the Bulletin identified intended options:

- Parity with rehabilitative services
- Plans would decide which habilitative services to cover, and would report on that coverage to HHS as a transitional approach

Pediatric Dental and Vision

- Intended dental options*:
  - Largest FEDVIP dental plan by enrollment
  - Separate CHIP program
- Intended vision option:
  - Largest FEDVIP vision plan by enrollment

*Would not include non-medically necessary orthodontic benefits

EHB Benchmark Selection: State Process

- State benchmark selection decision
- Notification to HHS of benchmark selection (Q3 2012)
- HHS analysis and verification of data collection
- Publication of actual benchmark plan in fall draft HHS payment notice (Q4 2012)

EHB Benchmark Selection

- Questions on EHB Benchmark Selection?
- For questions regarding the data submission, please contact your State Officer; they will put the State in contact with our Healthcare.gov Staff.

Actuarial Value Background

- The Affordable Care Act directs that non-grandfathered individual and small group plans inside and outside the Exchanges meet particular actuarial value (AV) targets
  - Bronze = 60% AV
  - Silver = 70% AV
  - Gold = 80% AV
  - Platinum = 90% AV

- AV must be calculated based on the provision of EHB to a standard population

Standard Population Options

- The American Academy of Actuaries produced a white paper detailing two approaches to calculating an AV based on a standard population:
  - Allow plans to use their own data, adjusted to reflect a standard population
  - Develop a dataset based on claims for a standard population, adjusted for expected Exchange enrollment

HHS Goals for Approach to AV Calculation

- Allow consumers to easily compare across plans
- Make the consumer shopping experience transparent and simple
- Promote competition on premiums
- Allow plans flexibility to design cost sharing structures

AV & CSR Bulletin

Pursuant to the AV/CSR Bulletin (released February 24, 2012), HHS intends to propose:

- Using a standard dataset for calculating AV to allow consumers to easily compare across plans
- Plans and issuers would have access to an AV calculator developed by HHS (expected to be complete fall 2012)
- States would be able to develop and use their own standard dataset subject to certain conditions
- De minimus variation of +/- 2 percentage points from the required metal tier AVs will be allowed

Intended Regulatory Approach: Factors in AV Calculations

- The AV calculator would include a limited number of inputs (deductibles and copay/coinsurance on major services), and HHS seeks comment on those inputs
- For plan types with non-standard features, HHS intends to propose that plans make adjustments separate from the calculator, requiring certification from an actuary
- HSA and HRA contributions would be treated similarly to first dollar coverage in the calculator

Intended Regulatory Approach: AV Calculator & User Experience

- AV calculator will be used for non-grandfathered individual and small group plans inside and outside the Exchanges.
- State regulators will verify AV using this calculator:
  - QHPs in State-based Exchanges
  - QHPs for State Partnerships
  - Plans outside the Exchange