Essential Health Benefits

Draft proposed rules on November 20, 2012 outlining the EHBs that qualified health plans must cover

- Based on section 1302 of the Affordable Care Act
- 10 EHB categories (emergency, hospitalization, maternity and new-born care, ambulatory, rehabilitative/habilitative, prescription drugs, pediatric services, preventive/wellness and chronic disease management, mental health/substance abuse, and laboratory services)
- Updates guidance on December 16, 2011
- Four options for choosing a "benchmark" (the largest plan by enrollment of any product in the state's small group health insurance market, one of the state's three largest state employee plans, one of the three largest plans for federal employees, or the state's largest non-Medicaid HMO)
- General rule: Adjust the benchmark if it does not include an EHB category by adopting coverage descriptions in another plan or actuarially equivalent coverage in that category
- Actuarial equivalence will be confirmed via an actuary's letter from the health insurance issuer to the State
- Exception to the general rule: Adjust the benchmark if it does not include pediatric vision or pediatric dental care by adopting federal employees' group health plan coverage or state CHIP coverage of those items
- If stand-alone dental plans are available in an Exchange, QHPs offered in that Exchange may exclude coverage of pediatric dental care

- Exception to the general rule: Adjust the benchmark if it does not include habilitative services, but states can define that item as they wish
- Exception to the general rule: Coverage of prescription drugs may vary among plans but usually must include at least the number of drugs in each drug category or class in the benchmark
- No provisions enabling States to impose restrictive formularies on QHPs
- States will not be liable for cost of state-mandated benefits enacted by the state before 2012
- HHS will publish a list of state-mandated benefits as a "reference tool" (unclear in the rule as to whether and how the "reference tool" will be binding on States)
- The rules also address cost-sharing, actuarial certification, and plan accreditation requirements
- A separate rule will be issued defining the minimum benefits that Medicaid must cover in 2014, which will incorporate EHBs as well as several other Medicaid provisions retained under the ACA
- These and all other proposed rules should be reviewed carefully for opportunities to comment, in order to secure potential changes in the final rule which may be permitted within the language of the applicable ACA provisions
- States will be held to the provisions of the final rule, which may differ substantially from the proposed rule

- Nongrandfathered plans in the individual and small group market both inside and outside the Exchange, Medicaid benchmark and benchmark equivalent coverage, and Basic Health Plans must cover the EHBs beginning in 2014.
- Self-insured group health plans, health insurance coverage in the large group market, and grandfathered health plans are not required to cover EHBs.

Benefits and Payments

Draft proposed rules on November 30, 2012 on health insurance "benefit and payment parameters for 2014"

- Expands on earlier CMS guidance and rule-making, the proposed rules provide greater specificity about reinsurance, risk corridors, and risk adjustments
- Risk adjustments are necessary to mitigate potential "adverse selection" enrollment risks for health insurance plans
- Earlier rules on those matters were published on March 23, 2012

The new proposed rules also provide further clarification on:

- Calculating medical loss ratios and rebates to enrollees for plans with low MLRs, to take into account the plans' payments and receipts for reinsurance, risk corridors, and risk adjustments in calculating MLRs
- Recalculating advance payment of premium tax credits and cost-sharing reductions under qualified health plans available through Exchanges, to take into account unanticipated mid-year changes in enrollees' household incomes
- Acceptable methods that employers may use to contribute toward employee and dependent coverage under the Small Business Health Options Program
- User fees that will be charged to health plans by Federally-facilitated Exchanges in States that elect not to operate their own Exchanges

The reinsurance, risk corridors, and risk adjustment rules are based on:

- Section 1341 of the ACA, which provides for state reinsurance programs to help stabilize premiums in the individual health insurance market for the first three years of Exchange operations in 2014-2016 (CMS will run it if states don't)
- Section 1342 of the ACA, which requires CMS to implement a risk corridor program in the individual health insurance market and the small group health insurance market in 2014-2016
- Section 1343 of the ACA, which provides for state risk adjustment programs in the individual and small group markets over an unlimited period, offering adjustments to health insurance issuers that disproportionately serve high cost populations, such as individuals with chronic conditions (CMS will run it if states don't)

The reinsurance pool will be at least $20 billion for 2014-2016, and $45 billion may be transferred among insurers through the risk adjustment program over the period 2014-2017

Payments and receipts under the risk corridor program in 2014-2016 will depend on the extent to which plans turn out to be outside the risk corridors, based on comparisons of the premiums collected by the plans to the allowable expenditures of the plans

Multi-State Health Insurance Plans

U.S. Office of Personnel Management issued a draft proposed rule on November 30, 2012 on the Multi-State Plan Program under section 1334 of the Affordable Care Act

The purpose of section 1334 is to spur competition on price and quality among health plans participating in Exchanges by enabling individuals and families using the Exchanges to freely choose private health plans already available through the OPM to 8 million federal employees, annuitants, and their dependents

The OPM benchmark plans currently available nationwide include Blue Cross Blue Shield Basic Option, Blue Cross Blue Shield Standard Option, and the Government Employees Health Association Standard Option

Many health insurers under contract with OPM select one of those benchmarks as a basis for a uniform benefits package that each insurer may offer nationwide through the Federal Employees Health Benefits program. Under the ACA, such insurers may offer two or more multi-state plans, at different AV levels (minimum of both silver and gold for each certified issuer), via Exchanges throughout the United States beginning in 2014.

Each MSP Issuer must offer a Child-Only plan at the same level as other plans certified by OPM for offer on the Exchange.

MSP Issuers may offer coverage in the Individual Market, and not the SHOP, throughout the phase-in period, but must provide a plan to OPM on how the MSP Issuer will expand its coverage to include offering on the SHOP in all states by the end of the phase-in period.

OPM is seeking state comment on whether or not to MSP Issuers should be required to participate in the SHOP from the outset, or to allow them to submit plans to include implementation of SHOP plans beyond the four-year phase-in period.

Consistent with QHPs, MSPs must include state mandates enacted after December 31, 2011.

OPM has stated in the proposed rule that it is aware of state concerns and interests regarding MSPs on state Exchanges, and is striving to ensure that neither the MSPs nor QHPs are either advantaged or disadvantaged in the Exchange market

OPM approved health plans will not need to apply separately for certification through each Exchange, but they must:

- Meet state law in all States in which they offer coverage **not inconsistent** with the regulation
- Agree to phase-in coverage for all States and the District of Columbia over a four year period if they do not already offer nationwide coverage. The proposed rule does not require the MSPP Issuer to cover the entire state during initial implementation, and is considering expanding the four-year deadline for nation-wide implementation regarding coverage for all service areas within a state.
- Meet OPM requirements aligned with ACA requirements for other plans participating in each Exchange

OPM is seeking comments on its proposed rules due to the need for collaboration and timely dispute resolution between OPM and Exchanges on OPM approval of multi-state plans that will be offered through Exchanges. OPM is seeking state comment on the scope and factors that OPM should consider when determining whether or not a state regulation and/or requirement may be inconsistent with regulations governing OPM in selecting and administering the MSPP.

OPM is also seeking state comments regarding specific areas of the proposed rule, including, but not limited to, appeals, rating, and benefit plan material and information.

- Appeals: OPM will resolve external appeals/claims disputes for MSPs as part of its contract administration. It is unclear in the proposed rule what, how or even if the OPM will provide data and/or reports to states regarding its appeals.

- Rating: MSPP Issuers will be required to use **only** the rating factors permitted by Section 2701 of the PHS Act, but also require these issuers to comply with state laws pertaining to rating factors. OPM intends to provide further guidance addressing methods for development of rates for the MSPP. OPM intends that each MSP set its premiums on a State-by –State basis (rather than a nation-wide premium). OPM plans to follow state rating laws as much as practical, and intends to work closely with states in approving rates for MSPs sold on their Exchange. Furthermore, each state may review the rates under its own procedures and processes and work with OPM for those instances where the state disagrees with OPM's rate determination.

- Benefit Plan Material and Information: As defined in the proposed rule, this would exclude plan policies and contracts. OPM is asking for states to comment on whether or not plan policies and contracts should be included as part of the benefit plan and information.

OPM reserves its authority to assess a User Fee for MSPs offered on the Exchanges. The purpose of assessments and user fees would be to cover the administrative costs of performing the contracting and certification of MSPs and of operating the program, functions typically conducted through an Exchange for QHPs. OPM seeks comments on the use of assessments and user fees to fund the MSPP.

The Director of OPM is given explicit statutory authority to negotiate with each MSP regarding medical loss ratio, profit margin and premiums to be charged, as well as other terms and conditions of coverage.

Network Adequacy Standards for MSPs would essentially mirror HHS Standards.

Service Areas: OPM proposed that MSPP Issuers adhere to service areas defined by the Exchange, but will not require that an MSP be offered in all defined service areas. MSPS will be required to submit plans for expanding to include all service areas. However, OPM is considering permitting an **exception** if an MSPP Issuer can only offer an MSP in a portion of a service area during the phase-in as long as the selection of the service area is not discriminatory.

The proposed rule **does not** include OPM's timeline for requiring accreditation of MSPs.

Health Insurance Market Reforms

HHS issued proposed rules on November 26 on acceptable variations in health insurance premiums based on:

- Family composition
- Geographic rating area
- Age (limited to 3:1 variation)
- Tobacco use (limited to 1.5:1 variation)

The proposed rules also implement ACA requirements on:

- Guaranteed availability of coverage
- Guaranteed renewability of coverage
- Student coverage
- Single risk poolCMS enforcement procedures in the individual and small group market
- Catastrophic plans
- Premium rates increase disclosure and reviews

Wellness Programs

HHS, Labor, and Treasury published proposed rules on November 26, 2012 on incentives for non-discriminatory wellness programs in group health plans. The proposed rules would:

- Increase the ceiling for rewards under a wellness program offered through a group health plan from 20% to 30% of the cost of coverage
- Increase the ceiling for rewards to 50% for wellness programs to prevent or reduce tobacco use

Enhanced Matching for Medicaid Eligibility and Enrollment Systems

CMS released a "frequently asked questions" bulletin on November 19, 2012 reiterating that:

- 90% matching for modernization of Medicaid eligibility and enrollment systems is not related to a state's decision about whether or not to proceed with Medicaid expansion for the new adult group
- Such systems nevertheless must meet all requirements related to integrating Medicaid systems with the Exchange
- 90% matching will remain available only through December 31, 2015