Issue Brief: Non-EHB Benefits in Qualified Health Plans and Private Option

Issue Overview

Qualified Health Plans (QHPs) are required to cover the ten Essential Health Benefits (EHBs) mandated in the Affordable Care Act, but are not limited to coverage of those benefits. Benefits that are in addition to the EHBs (also called "non-EHBs") may be included in the plans; common non-EHBs include adult vision, adult dental, and coverage of state-mandated offerings.

Individuals with incomes above 138% who purchase plans that include non-EHBs through the FFM may receive Advanced Premium Tax Credits for the EHB portion of premiums only. (See 26 CFR § 1.36B in Appendix A). Issuers submit the portion of premium allocated to EHBs in the Actuarial Memorandum accompanying QHP applications, and individuals who select plans with non-EHBs do not receive subsidies towards the premium allocated to non-EHBs. In addition, the APTC calculation is based upon only the EHB portion of the second lowest cost silver plan.

Currently, the Arkansas Private Option program provides premium assistance for the purchase of Silver QHPs, including premium coverage for plans that offer non-EHBs as part of the benefit package. The additional benefits allow plan differentiation among carriers and allow issuers to respond to consumer demand. However, unlike the FFM, non-EHBs are currently included in the plan premium covered by Medicaid and cannot at this time be separately allocated for Medicaid recipients.

The options listed below seek to address the differences in process between the FFM and AR Private Option program. The recommendation of the AID stakeholder committees should take into account the Healthcare Independence Act which requires that Private Option coverage is provided through silver-level QHPs; the purposes of the law include increased competition in the marketplace, increased competition and delivery system efficiencies, improved access, and other market-driven goals. (See Appendix B for selected sections of the Act). In addition, mandated offerings are required to be submitted as part of Qualified Health Plans, the approach taken to manage non-EHB benefits for Medicaid Private Option plans must take into account that some plans must include mandatory offerings.

Options

The table below lists potential options for Qualified Health Plans offered in the Marketplace.

Options for managing non-EHBs in Qualified Health Plans (Silver Plans)

	Option A	Option B	Option C	Option D
	Require submission of mirrored silver plans: one with non-EHBs and one with only EHBs and provide premium assistance only for EHBs. Require premium assistance eligible consumers to pay the remaining premium if they choose a plan with non-EHBs*	Provide premium assistance only for EHBs in Private Option program; require issuers to enroll Medicaid recipients and absorb costs for non-EHBs if issuers choose to include non-EHBs**	Allow only EHBs in Silver Plans; include non-EHBs as no-cost plan riders only available to consumers > 138% FPL***	Allow only EHB benefits in silver QHPs
Impact on individual plans > 138%	No direct impact, non-EHBs would be offered to consumers.	Non-EHBs would be offered to consumers. May result in issuers voluntarily excluding non-EHBs.	Plans with embedded non-EHBs will no longer be offered in silver plans; non-EHB services will likely cost more for individuals willing to purchase through riders. Issuers may choose to limit non-EHB offerings (that are not mandatory offerings).	Non-EHB services will no longer be available, plan differentiation will be limited. This option would need to be coordinated with the requirement that mandatory offerings are available in QHP submissions (and not just offered as riders).
Impact on Private Option plans	Some consumers have to pay supplemental costs for the same benefit package, others choose plans without non-EHBs.	No impact, consumers keep plans with non-EHBs.	Non-EHB services will no longer be available, plan differentiation will be limited.	Non-EHB services will no longer be available, plan differentiation will be limited.
Results in cancelled plans?	No; but PO consumers are likely to switch to mirror plans with no EHBs to avoid premiums.	Undetermined—some issuers may change plans offered due to this requirement.	Yes, all plans in the individual market will be cancelled.[i]	Yes, all plans in the individual market will be cancelled.
Issuer Administrative Burden	High–administrative burden requires annual submission of additional plans. (Allocation of premium to non-EHBs is already required for FFM participation and does not add to burden)	Increased – moderate additional administrative burden to manage different plan cost structures for Private Option	High – All plans must be modified and non-EHBs filed as no-cost riders have additional administrative requirements	Low (After initial plan modifications)
Department Administrative Burden	Increased – requires review of additional plans and management of additional plan selection and payment for some PO consumers; verification that premium accurately allocated to EHBs	Low – requires verification that premium is accurately allocated to EHBs	Increased – requires review of additional plans due to rider arrangement; lower administrative burden for Medicaid agency	Moderate – review of EHB-only compliance (including limiting benefit categories to similar coverage levels as the benchmark plan) will increase administrative burden initially. In subsequent years this would be reduced

*Mirror plans would be required because Medicaid recipients cannot be required to pay premiums in order to receive essential health benefits. This option would need to be approved by CMS; it is possible that CMS would not allow this option because consumers would be required to pay premiums if a plan with non-EHBs was selected.

** Issuers would have to actuarially certify that EHB premiums in the individual FFM market and Private Option program were not affected by the offering of "free" non-EHBs in the Private Option. Issuers would offer these benefits in the Private Option as a competitive strategy.

***Note that CMS is requiring that riders be included in QHP submissions; AID is proposing a process to manage submission of riders or plans with mandated offerings in the QHP templates

APPENDICES

Appendix A: IRS Rule 26 CFR Parts 1 and 602

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 1
[TD 9590]
RIN 1545–BJ82
Health Insurance Premium Tax Credit

26 CFR § 1.36B

…(j) Additional benefits—(1) In general. If a qualified health plan offers benefits in addition to the essential health benefits a qualified health plan must provide under section 1302 of the Affordable Care Act (42 U.S.C. 18022), or a State requires a qualified health plan to cover benefits in addition to these essential health benefits, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under paragraph (d)(1) or (d)(2) of this section.

Example 1. (i) Taxpayer B enrolls in a qualified health plan that provides benefits in addition to the essential health benefits the plan must provide (additional benefits). The monthly premium for the plan in which B enrolls is $385 (Amount 1), of which $35 is allocable to the additional benefits. The premium for B's applicable benchmark plan is $440, of which $40 is allocable to the additional benefits. The excess of the premium for B's applicable benchmark plan over B's $60 contribution amount (which is the product of B's household income and the applicable percentage) is $380 per month (Amount 2).

(ii) Under this paragraph (j), the premium for the qualified health plan in which B enrolls and the applicable benchmark premium each is reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, Amount 1 is reduced to $350 ($385-$35), the premium for B's applicable benchmark plan is reduced to $400 ($440-$40), and Amount 2 is reduced to $340 ($400 less $60). B's premium assistance amount for a coverage month is $340, the lesser of Amount 1 and Amount 2.

Example 2. (i) The facts are the same as in Example 1, except that B's applicable benchmark plan provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under paragraph (j) of this section, only the amount of the monthly premium for the plan in which B enrolls is reduced by the portion of the premium that is allocable to the additional benefits provided under that plan, and Amount 1 is $350 ($385-$35). The premium for B's applicable benchmark plan is not reduced under this paragraph (j), and Amount 2 is $380 ($440-$60). B's premium assistance amount for a coverage month is $350, the lesser of these two amounts.

Appendix B: Non-EHBs and Maximum Out of Pocket Amounts

For purposes of calculating AV, non-EHB benefits may not accumulate towards MOOP amounts. Per section 1302(a) of the Affordable Care Act, the term ‘‘essential health benefits package’’ must consist of those benefits defined under section 1302(b), limits on cost-sharing for such coverage in accordance with section 1302(c), and a package that meets applicable metal levels. Section 1302(c) contains cost sharing requirements, including MOOP limitations. Furthermore, 1302(d) on AV clarifies that the level of coverage of a plan shall be determined on the basis that the EHB benefits be provided to a standard population. However, operationally, a plan may (but is not required to) count cost sharing for non–EHB towards the MOOP.

Appendix C: Selected Language from the Arkansas Healthcare Independence Act of 2013

20-77-2105. Administration of the Health Care Independence Program.

…(c) The program shall include premium assistance for eligible individuals to enable their enrollment in a Qualified Health Plan through the Health Insurance Marketplace.
(d)(1) The Department of Human Services is specifically authorized to pay premiums and supplemental cost-sharing subsidies directly to the Qualified Health Plans for enrolled eligible individuals.
(2) The intent of the payments under subdivision (d)(1) of this section is to increase participation and competition in the health insurance market, intensify price pressures, and reduce costs for both publicly and privately funded health care.
(e) To the extent allowable by law:
(1) The Department of Human Services shall pursue strategies that promote insurance coverage of children in their parents' or caregivers' plan, including children eligible for the ARKids First Program Act, § 20-77-9
1101 et seq., commonly known as the "ARKids B program";…

20-77-2106. Standards of healthcare coverage through the Health Insurance Marketplace.

(a) Healthcare coverage shall be achieved through a qualified health plan at the silver level as provided in 42 U.S.C. §§ 18022 and 18071, as existing on January 1, 2013, that restricts cost sharing to amounts that do not exceed Medicaid cost-sharing limitations.
(b)(1)
All participating carriers in the Health Insurance Marketplace shall offer healthcare coverage conforming to the requirements of this subchapter…

[i] The plans may be cancelled due to substantive difference in plan design, such as benefits offered. Additional guidance is expected from CCIIO on plan continuity (“same plan guidelines”), but the removal of non-EHB benefits is likely a substantive plan change that will result in plan cancellation. Consumers would be required to re-enroll in a new plan.