



VCU Medical Center

Office of Health Innovation

Final Rule: Essential Health Benefits

Description: This final rule outlines Exchange and issuer standards related to coverage of essential health benefits and actuarial value. This rule also lays out a timeline for qualified health plans to be accredited in Federally-facilitated Exchanges. It also includes an amendment which provides an application process for the recognition of additional accrediting entities for purposes of certification of qualified health plans.

Major Provisions

The regulations outlined in this proposed rule would be codified in **45 CFR parts 147, 155, and 156**.

Part 156 outlines the standards for issuers of QHPs, including with respect to participation in an Exchange. The Affordable Care Act requires that health plans in the individual and small-group markets—both inside and outside the health insurance exchanges—include a core package of essential services. **Essential health benefits** must be equal in scope to the benefits covered by a typical employer plan and include items and services within at least the following 10 general 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
10. Pediatric services, including oral and vision care

An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

The actuarial value component of essential health benefits is determined as the percentage of total average costs for benefits that a plan would cover. In general, AV can be considered a general summary measure of health plan generosity.

- In 2014, nongrandfathered health plans in the individual and small-group markets must meet certain “metal” levels, depending on whether they are a bronze (60%), silver (70%), gold (80%) or platinum (90%) plan.
- In addition, issuers may offer catastrophic-only coverage with lower AV for eligible individuals.
- The final rules establish annual cost-sharing limits on regulated plans. In 2014, individual plans are limited to \$5,000 in cost-sharing and \$2,000 in deductibles. In subsequent years, these limits are to be increased by a premium adjustment percentage, to be determined by HHS, for that year. Family plans are also subject to similar limits, which for any year are defined as twice the individual plan limits for that year.
- Beginning in 2015, HHS will accept state-specific data sets for the standard population if states choose to submit alternate data for the calculator.

Each State may set its own EHB package based on a "base-benchmark plan," which shall become the model EHB package for all applicable plans in that State. Thereafter, all applicable plans subject to the EHB requirement will have to offer benefits that are substantially equal to the benefits offered in the base-benchmark plan. The final rules allow each State to select its base-benchmark plan from among four options, including:

1. the largest health plan by enrollment in the State's small group market;
2. any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees;
3. any of the largest three national Federal Employees Health Benefits Program plan options; and
4. the coverage plan with the largest insured commercial non-Medicaid enrollment offered by an HMO operating in the State. If a State fails to select a base-benchmark plan from among these options, the default EHB package will be the largest plan by enrollment in the State's small group market.

The Final Rule lists EHB-benchmark plans for the 50 states, the U.S. territories and the District of Columbia. Each state may select a benchmark plan to serve as the standard for plans required to offer EHB in the State. As described in §156.110, an EHB-benchmark plan must offer coverage in each of the 10 statutory benefit categories. Below is the EHB-benchmark for Virginia.

State	Plan Type	Issuer and Plan Name	Supplemente d Categories	Supplementary Plan Type	Habilitativ e Services
Virginia	Plan from largest small group product	Anthem Health Plans of VA PPO Keycare 30 with KC30 Rx plan 10 30 50 OR 20	Pediatric Oral Pediatric Vision	FEDVIP FEDVIP	Yes

Part 147 outlines proposed standards for health insurance issuers in the small group and individual markets related to health insurance reforms.

- A health insurance issuer offering health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package as defined in section 1302(a) of the Affordable Care Act effective for plan or policy years beginning on or after January 1, 2014.
- If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d)(1) of the Affordable Care Act, the issuer must offer coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

Part 155 outlines the proposed standards for states relative to the establishment of Exchanges and outlines the proposed standards for Exchanges related to minimum Exchange functions.

- A State may require a QHP to offer benefits in addition to the essential health benefits.
- A State-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits.
- The Exchange shall identify which state-required benefits are in excess of EHB.
- State-required benefits that are not included in the benchmark apply to QHP markets in the same way they apply in the current market.
- Accreditation Standards: A federally-facilitated exchange, including State Partnership Exchanges, will accept existing health plan accreditation from the National Committee for Quality Assurance (NCQA) and URAC on issuer's commercial or Medicaid lines of business until the fourth year of certification of a qualified health plan (QHP).