DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Parts 147, 155, and 156
[CMS-9980-F]
RIN 0938-AR03

Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

AGENCY: Health Exchange

Essential health benefits package or EHB package means the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the ten statutory categories of benefits, as described in §156.110(a) of this subchapter; provides the benefits in the manner described in §156.115 of this subchapter; limits cost sharing for such coverage as described in §156.130; and subject to offering catastrophic plans as described in section 1302(e) of the Affordable Care Act, provides distinct levels of coverage as described in §156.140 of this subchapter.

Subpart B – Essential health benefits package

Sec. 156.

156.100 State selection of benchmark.
156.105 Determination of EHB for multi-state plans.
156.110 EHB-benchmark plan standards.
156.115 Provision of EHB.
156.122 Prescription drug benefits.
156.125 Prohibition on discrimination.
156.130 Cost-sharing requirements.
156.135 AV calculation for determining level of coverage.
156.140 Levels of coverage.
156.145 Determination of minimum value.
156.150 Application to stand-alone dental plans inside the Exchange.

§156.100 State selection of benchmark.

Each State may identify a single EHB-benchmark plan according to the selection criteria described below:

(a) State selection of base-benchmark plan. The options from which a base-benchmark plan may be selected by the State are the following:

(1) Small group market health plan. The largest health plan by enrollment in any of the three largest small group insurance products by enrollment, as defined in §159.110 of this subpart, in the State's small group market as defined in §155.20 of this subchapter.

(2) State employee health benefit plan. Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.

(3) FEHBP plan. Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits eligible federal employees under 5 USC 8903.

(4) HMO. The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.

(b) EHB-benchmark selection standards. In order to become an EHB-benchmark plan as defined in §156.20 of this subchapter, a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in §156.110 of this subpart; and

(c) Default base-benchmark plan. If a State does not make a selection using the process defined in §156.100 of this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State's small group market. If Guam, the U.S. Virgin Islands, American Samoa, or the Northern Marianna Islands do not make a benchmark selection, the default base-benchmark plan will be the largest FEHBP plan by enrollment.

PPACA §156.110 EHB-benchmark plan standards.

An EHB-benchmark plan must meet the following standards:
(a) EHB coverage. Provide coverage of at least the following categories of benefits:

(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.

For a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:

(i) For self-only coverage--the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in paragraph (e) of this section.
(ii) For other than self-only coverage--twice the dollar limit for self-only coverage described in paragraph (a)(2)(i) of this section.
(b) Annual limitation on deductibles for plans in the small group market. (1) For a plan year beginning in calendar year 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(i) For self-only coverage--$2,000; or
(ii) For coverage other than self-only--$4,000.

(2) For a plan year beginning in a calendar year after 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(i) For self-only coverage--the annual limitation on deductibles for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage as defined in paragraph (e) of this section; and
(ii) For other than self-only coverage--twice the annual deductible limit for self-only coverage described in paragraph (b)(2)(i) of this section.

(3) A health plan’s annual deductible may exceed the annual deductible

§156.140 Levels of coverage.

(a) General requirement for levels of coverage. AV, calculated as described in §156.135 of this subpart, and within a de minimis variation as defined in paragraph (c) of this section, determines whether a health plan offers a bronze, silver, gold, or platinum level of coverage.
(b) The levels of coverage are:

(1) A bronze health plan is a health plan that has an AV of 60 percent.
(2) A silver health plan is a health plan that has an AV of 70 percent.
(3) A gold health plan is a health plan that has an AV of 80 percent.
(4) A platinum health plan is a health plan that has as an AV of 90 percent

What is Actuarial Value (AV)?

Actuarial value is a measure of the percentage of expected health care costs a specific health plan will cover for the "standard" population. Actuarial value is generally calculated using the ratio of:

$$\frac{\textbf{the total expected payments by the plan for essential health benefits}}{\textbf{the total expected costs of the "standard" population for essential health benefits}}$$

For example, a plan with a 70 percent actuarial value would be expected to pay, on average, 70 percent of a standard population's expected medical expenses for essential health benefits. The individuals covered by the plan would be expected to pay, on average, the remaining 30 percent of the expected expenses in the form of deductibles, co-payments, and coinsurance.

The exact process for determining a "standard" actuarial value across multiple plans has yet to be finalized. However, HHS has proposed rules governing the calculation of actuarial value.

Overview of the Actuarial Value (AV) Calculator

The Actuarial Value Calculator (AVC) is designed to give an estimate of network liability for a given plan design. The AVC uses 2010 claims and enrollment data from a national commercial database to provide information on utilization and cost-sharing for a standard population of enrollees. The proposed AV calculator is posted on the CCIIO website.

To give health plans some help in meeting the metal levels, HHS has proposed that a plan can meet a particular metal level if its AV is within 2 percentage points of the standard. For example, a silver plan may have an AV between 68 percent and 72 percent. In addition, the proposed rule provides flexibility for issuers in the small group market by permitting issuers to exceed annual deductible limits to achieve a particular metal level.

Under the proposed rule, beginning in 2015, HHS will also accept state-specific data sets for the standard population if states choose to submit alternate data for the calculator.

What is Actuarial Value (AV)?

Actuarial value is a measure of the percentage of expected health care costs a specific health plan will cover for the "standard" population. Actuarial value is generally calculated using the ratio of:

$$\frac{\textbf{the total expected payments by the plan for essential health benefits}}{\textbf{the total expected costs of the "standard" population for essential health benefits}}$$

For example, a plan with a 70 percent actuarial value would be expected to pay, on average, 70 percent of a standard population's expected medical expenses for essential health benefits. The individuals covered by the plan would be expected to pay, on average, the remaining 30 percent of the expected expenses in the form of deductibles, co-payments, and coinsurance.

The exact process for determining a "standard" actuarial value across multiple plans has yet to be finalized. However, HHS has proposed rules governing the calculation of actuarial value.

Proposed Rules for a Standardized Actuarial Value (AV)

The Department of Health and Human Services (HHS) has provided information on actuarial value standards in several phases:

- On November 20, 2012, HHS published a proposed rule that outlines health insurance issuer standards related to the coverage of essential health benefits and the determination of actuarial value.

To standardize the calculation of actuarial value for health insurance issuers, HHS has proposed utilizing a publicly available "Actuarial Value Calculator". The idea is that health plans can use this calculator to determine actuarial values based on a national, standard population determined by HHS.

Overview of the Actuarial Value (AV) Calculator

The Actuarial Value Calculator (AVC) is designed to give an estimate of network liability for a given plan design. The AVC uses 2010 claims and enrollment data from a national commercial database to provide information on utilization and cost-sharing for a standard population of enrollees. The proposed AV calculator is posted on the CCIIO website.

To give health plans some help in meeting the metal levels, HHS has proposed that a plan can meet a particular metal level if its AV is within 2 percentage points of the standard. For example, a silver plan may have an AV between 68 percent and 72 percent. In addition, the proposed rule provides flexibility for issuers in the small group market by permitting issuers to exceed annual deductible limits to achieve a particular metal level.

Under the proposed rule, beginning in 2015, HHS will also accept state-specific data sets for the standard population if states choose to submit alternate data for the calculator.

How Actuarial Value (AV) Accounts for HRAs and HSAs

HHS has proposed that the annual employer contributions to HSAs and amounts newly made available under HRAs for the current year should count within the plan design. This treatment of HSA and HRA contributions is similar to how other employer contributions toward cost-sharing are treated within the plan design, such that a plan with a $0 deductible has the same AV as a plan with a $1,000 deductible plus a $1,000 HSA or HRA.

Why Actuarial Value Matters to You

The Affordable Care Act (ACA) establishes various tiers of health insurance coverage. These tiers are used for three primary purposes:

1. To set the minimum amount of coverage you must have to satisfy the requirement that you be insured or pay a federal tax penalty beginning in 2014.
2. To establish standardized levels of insurance you and your small employer (if applicable) can buy beginning in 2014.
3. To provide benchmarks for premium tax subsidies (if applicable) when you buy your own insurance in the individual health insurance exchange beginning in 2014.

Remember:

1. **You will be required to have insurance that is at least at the *bronze* level (a 60% actuarial value) or pay a federal tax penalty.**
2. **If you buy your own insurance in the individual health insurance exchange, you may be eligible for premium tax subsidies. The premium tax subsidies are based on family income and the premium of the second lowest cost *silver* plan (a 70% actuarial value).**