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Health Care Reform: Essential Health Benefits and Actuarial Value

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The essential health benefit (EHB) requirements of the Patient Protection and Affordable Care Act (ACA) significantly impacted the landscape of benefit plans offered in the individual and small group markets by prescribing the benefits that must be covered, implementing limits on annual cost sharing (and, temporarily, on small group deductibles), and limiting benefit plans based on the percentage of estimated costs covered by the plan (i.e., bronze, silver, gold and platinum tiers).

Section 1302 of the ACA defines an "Essential Health Benefits Package" as coverage that:

- Provides EHBs
- Complies with certain cost-sharing limitations
- Provides a prescribed level of coverage, as measured by the plan's actuarial value (AV).

All non-grandfathered individual and small group policies beginning on or after Jan. 1, 2014, are required to provide the EHB package. (This requirement was later revised to exclude "transitional" non-grandfathered individual and small group policies, which are policies that were in effect on Oct. 1, 2013, thus allowing individuals and small groups who wanted to remain on pre-ACA policies to do so.)

In addition, the U.S. Department of Health and Human Services (HHS) determined that all non-grandfathered coverage, including large group and self-funded plans, was required to comply with the annual cost-sharing limitation portion of the EHB package requirements (discussed in more detail below).

ESSENTIAL HEALTH BENEFITS (EHBs)

The ACA itself requires that EHBs include coverage of the 10 categories shown in the table in Figure 1 and instructed HHS to consider the following when developing their full definitions:

- Scope equal to the scope of benefits provided under a typical employer plan.
- Appropriate balance among each of the 10 categories in Figure 1 "so that benefits are not unduly weighted toward any category."
- Avoidance of discrimination (via coverage decisions, reimbursement rates, incentive programs or benefit design) related to age, disability or life expectancy.
- Allowance for the health care needs of diverse segments of the population, such as women, children, and people with disabilities.
- Prevention of denial of benefits on the basis of a person's age, life expectancy, disability (actual or predicted), degree of medical dependency, or quality of life.
- Provision of coverage for emergency department services without requiring prior authorization or any limitation on place of service (i.e., provider network), including cost-sharing differentials.
- Periodic review of the EHB definition to determine whether:
  - Cost or coverage barriers to accessing needed services exist.
  - The definition needs to be revised to account for changes in "medical evidence or scientific advancement."

Figure 1

ACA Essential Health Benefits, 10 Required Service Categories

1. Ambulatory patient services	6. Laboratory services
2. Prescription drugs	7. Maternity and newborn care
3. Emergency services	8. Preventive and wellness services and chronic disease management
4. Rehabilitative and habilitative services and devices	9. Mental health and substance abuse disorder services
5. Hospitalization	10. Pediatric services*, including oral and vision care

* Ultimately defined as services for individuals under the age of 19 years.

State determination of EHBs: In response to the ACA's directive, HHS asked the Institute of Medicine (IOM) to recommend a process to help HHS define benefits that should be considered EHBs and periodically update the benefits as prescribed by the ACA. Based on the IOM's recommendations, HHS established a process by which a state would select a "base-benchmark plan"—an existing plan that might need to be adjusted to meet all EHB requirements. The adjusted "base-benchmark plan" is called the "EHB benchmark plan" and serves as a reference plan that reflects the scope of services and service (not cost-sharing) limits for carriers offering non-grandfathered individual and small group coverage. The EHB benchmark plan in each state was to apply for at least the 2014 and 2015 benefit years and now applies for 2016 as well. In February 2015, HHS released guidance for states to make EHB benchmark plan changes for 2017.

Each state was allowed to select one of the following types of health plans as its base-benchmark plan:

- The largest plan in any of the three largest small group products in the state's small group market
- Any of the largest three state employee health benefit plans
- Any of the largest three Federal Employees Health Benefits Program (FEHBP) plan options
- The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

If a state did not select a plan, the base-benchmark plan for that state defaulted to the largest plan in the largest product in the state's small group market. Ultimately, the base-benchmark plan in 44 of the 50 states is a small group plan. Four of the remaining states selected a commercial HMO and two selected a state employee plan.[1]

Because many base-benchmark plans did not include coverage of all 10 prescribed categories, states were required to add the missing category from another base-benchmark plan option to create the EHB benchmark plan. For example, most employer plans did not cover pediatric dental and/or vision services, so almost every state had to supplement these services and most did so with Federal Employees Dental and Vision Insurance Program (FEDVIP), although 21 states used the pediatric dental coverage from their Children's Health Insurance Program (CHIP).[2] Three states had to add mental health coverage (all three used FEHBP coverage).

Another category that presented difficulties was "habilitative" services because many pre-ACA plans did not specifically define or provide coverage for them. As a result, if the base-benchmark plan did not include habilitative services (21 did not), HHS allowed states to determine the services to be included in this category. If a state chose not to define habilitative services, issuers are required to cover habilitative services that are similar in scope, amount and duration to benefits covered for rehabilitative services. Alternatively, an issuer was allowed to provide HHS with a list of the habilitative services it intended to cover.

The ACA explicitly permits states to require issuers to offer benefits in addition to EHBs but requires them to make payments (to the enrollee or issuer) to defray the cost of the additional benefits.[3] As such, state-mandated benefits that were enacted on or before Dec. 31, 2011, (regardless of when effective) can be considered EHBs in that state. Such benefits would apply in the same way they applied in 2011 (e.g., a benefit required in the individual market but not in the small group market would be considered an EHB only in the individual market, not in the small group market).

At each state's discretion, issuers are allowed to substitute benefits (or sets of benefits) that are actuarially equivalent to the benefits being replaced, subject to the nondiscrimination requirements. Substitution is only allowed within one of the benefit categories (i.e., not between categories) in order to comply with the requirement that benefits are not unduly weighted toward any category. However, substitution within the prescription drug category is not allowed.

Finally, an issuer is not allowed to include the following services as EHBs:

- Routine non-pediatric dental services
- Routine non-pediatric eye exam services
- Non-medically necessary orthodontia
- Long-term/custodial nursing home care.

EHB changes for 2016/2017: HHS' Notice of Benefit and Payment Parameters for 2016, issued on Feb. 20, 2015, makes the following EHB changes:

- **Definition/clarification of habilitative services:** Beginning with the 2016 plan year, issuers will no longer be allowed to define the habilitative services covered by the plan (and notify HHS). Instead, HHS has adopted a uniform definition of habilitative services to be used by states and issuers, although states are allowed to maintain their previous definitions. The goal of this change is to minimize variability in benefits and lack of coverage for habilitative services versus rehabilita-

Most employer plans did not cover pediatric dental and/or vision services, so almost every state had to supplement these services.

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tive services. In addition, plans are not allowed to impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. For plan years beginning on or after Jan. 1, 2017, issuers must impose *separate* limits on habilitative and rehabilitative services.

- **Coverage of pediatric services:** Coverage of pediatric services must continue until the end of the month in which the enrollee turns 19.
- **Examples of possible discriminatory plan designs:** Since the original EHB rules were finalized, HHS has become aware of benefit designs they believe discourage enrollment based on age or health conditions—making the plans discriminatory. For example, a plan imposing an age limit on hearing aids (e.g., only covered up to six years of age), placement of drugs into the formulary tier with the highest cost sharing, or not having a certain drug on the formulary can discriminate on the basis of health conditions.
- **Prescription drug coverage:** Currently, plans are required to cover the greater of one drug per U.S. Pharmaceutical (USP) category or class or the same number of drugs in each USP category and class as the state's EHB benchmark plan. Because USP was developed for Medicare, issuers have a hard time complying with this requirement (e.g., some drugs used for non-Medicare populations aren't on the list, newly approved drugs aren't counted, some drugs were counted in multiple USP classes, etc.). In its proposed Notice of Benefit and Payment Parameters for 2016, HHS considered replacing this drug count standard with a requirement that plans adopt a pharmacy and therapeutics (P&T) committee and use that committee to ensure that the plan's formulary drug list covers a sufficient number and type of prescription drugs. The final notice, however, adds the P&T committee requirement to the USP drug count requirement and specifies standards related to P&T committee meetings, membership, range of drugs included on formulary drug list, etc. The new approach will be required for plan years beginning on or after Jan. 1, 2017.
- **Base-benchmark plans:** Each state will be allowed to select a new base-benchmark plan for 2017 using 2014 plans.

COST-SHARING LIMITATIONS

The ACA defines cost sharing as "any expenditure required by or on behalf of an enrollee with respect to essential health benefits." As such, ACA-prescribed cost-sharing limits apply to deductibles, coinsurance, copays and similar items, but do not apply to premiums, balance billing for out-of-network providers, or services that aren't covered by the plan.

Annual limit on cost sharing: The ACA places a cap on the amount of cost sharing an enrollee can incur each year for in-network EHBs. HHS initially (in November 2012) proposed that these annual limits on cost sharing prescribed by the ACA (i.e., out-of-pocket (OOP) maximums)—see the table in Figure 2 for amounts—were applicable only to non-grandfathered individual and small group plans effective on or after Jan. 1, 2014. In its final rule, HHS clarified that the annual limits apply to all group health plans, including large group and self-funded plans.

For 2014, the annual limit on cost sharing was the OOP limit for high-deductible health plans (HDHPs) per the Internal Revenue Code. After 2014, the annual limitation on cost sharing increases by a "premium adjustment percentage," which is set by HHS. Figure 2 displays the annual cost-sharing limits for 2014, 2015 and 2016.

Figure 2

ACA-Mandated Annual Cost-Sharing Limits, 2014-2016

Plan Year	Self-Only Coverage	Non-Self-Only Coverage
2014	$6,350	$12,700
2015	$6,600	$13,200
2016*	$6,850	$13,700

* Beginning in 2016, a family HDHP cannot require an individual in the family plan to exceed the annual limitation on cost sharing for self-only coverage.

On Feb. 20, 2013, recognizing that many issuers use separate (often subcontracted) companies to administer a portion of their benefits (e.g., prescription drugs, mental health), the U.S. Departments of Labor, HHS, and the Treasury issued a frequently asked questions (FAQs) document allowing plans extra time to administer the annual cost-sharing limit across all EHBs. For the first plan year beginning on or after Jan. 1, 2014, the annual limit on cost sharing was considered satisfied for carriers using multiple administrators if both of two conditions are met:

1. The plan complied with the annual limit for its major medical coverage.
2. Any separate OOP maximum on other, non-major medical coverage (e.g., the prescription drug coverage administered by a separate entity) did not exceed the ACA's annual cost-sharing limit. If the other non-major medical coverage did not have an OOP limit, the plan was not required to add one for this transition year. It was noted, however, that plans had to continue to comply with existing mental health parity regulations.

Small group deductible limits: The ACA prescribed that, beginning in 2014, deductibles for non-grandfathered small group plans cannot exceed $2,000 for self-only coverage and $4,000 for non-self-only coverage. Recognizing the difficulty this

limit placed on designing a bronze plan (see the AV section below for more information), HHS allowed issuers to use a deductible greater than the $2,000/$4,000 maximum "if it cannot reasonably reach a given level of coverage (metal tier) without doing so." As a result, many small group bronze plans and even some small group silver plans had deductibles that exceeded the $2,000/$4,000 maximum.

Originally, HHS proposed that the small group deductible limit for plan years after 2014 be increased by the same "premium adjustment percentage" used to establish the annual limitation on cost sharing and in the final 2015 Notice of Benefit and Payment Parameters, increasing the limit to $2,050/$4,100. However, on April 1, 2014, the Protecting Access to Medicare Act of 2014 repealed the limit on small group deductibles.

ACTUARIAL VALUE REQUIREMENTS

The ACA defines "actuarial value" as the percentage of expected EHB costs a health plan will cover for a standard population. AV can be described by this formula:

Anticipated Plan-Paid Allowed Charges for EHB Coverage for Standard Population

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Anticipated Total Allowed Charges for EHB Coverage for Standard Population

For example, a plan whose AV is 80 percent is anticipated to cover 80 percent of a standard member's costs for EHBs and the member is expected to cover the other 20 percent through cost sharing.

For plan years beginning on or after Jan. 1, 2014, plans must be categorized as bronze (60 percent AV), silver (70 percent AV), gold (80 percent AV) or platinum (90 percent AV) in order to be sold in the individual or small group market (except for grandfathered plans and "transitional" plans as described at the beginning of this article). Each plan must qualify for one of these metallic tiers by having an AV that meets the applicable de minimis AV range shown in the table in Figure 3.

Figure 3

ACA-Prescribed AVs for Metallic Tiers

Metallic Tier	Prescribed AV	De Minimis AV Range
Bronze	60%	58%-62%
Silver	70%	68%-72%
Gold	80%	78%-82%
Platinum	90%	88%-92%

In addition, an issuer may offer a catastrophic plan, which does not technically have an AV. Catastrophic plans are sold in the individual market to enrollees under the age of 30 or others for whom insurance is deemed unaffordable. While there is no AV requirement for catastrophic plans, there are several benefit design requirements:

- The deductible must equal the annual cost-sharing limit for the year ($6,850 for 2016).
- At least three primary care visits must be covered before the deductible has to be satisfied.
- There can be no cost sharing for preventive services.

An issuer has two options if it determines the AVC doesn't appropriately handle a particular benefit design.

Cost-sharing reduction (CSR) variations: Each silver plan offered in the individual on-exchange market must have an associated set of CSR variation plans that have lower member cost sharing than the standard silver plan. Enrollees with incomes below 250 percent of the Federal Poverty Limit (FPL) are eligible to enroll in one of these CSR variation plans and the issuer is reimbursed for the cost-sharing difference by HHS. These variation plans have a smaller de minimis range and lower annual cost-sharing limits than standard plans, as shown in the table in Figure 4.

Figure 4

ACA-Prescribed AVs for CSR Variation Plans

Income	2016 Annual Cost-Sharing Limit*	Prescribed AV	De Minimis AV Range
100%-150% FPL	$2,250/$4,500	94%	93% - 95%
150%-200% FPL	$2,250/$4,500	87%	86% - 88%
200%-250% FPL	$5,450/$10,900	73%	72% - 74%

* Self-only/Non-self-only

The 73 percent CSR variation plan must also have an AV that differs from the associated standard silver plan's AV by at least 2 percent. Therefore, if the standard silver plan's AV is 71 percent, the 73 percent CSR variation plan's AV must be at least 73 percent.

Actuarial Value Calculator (AVC): Issuers are required to use HHS' AVC to qualify a benefit plan as bronze, silver, gold or platinum (or one of the CSR variations), with certain exceptions (discussed below).

The AVC is a Microsoft Excel tool that calculates the AV for a given benefit plan using claims continuance tables based on a standard population that has been determined to resemble enrollees in the 2014 individual and small group markets (for the 2014 AVC). Because utilization of health care services is influenced by the level of member cost sharing, the AVC uses a separate continuance table for

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Figure 5

Implied Impact of Cost Sharing on Utilization in the AVC (2014-2016)

Metal Tier	Medical	Prescription Drug	Total
Platinum	14%	29%	17%
Gold	7%	15%	9%
Silver	1%	14%	3%
Bronze	0%	0%	0%

each metallic tier. The table in Figure 5 displays the implied impact of cost sharing on utilization of services, relative to the bronze plan, in the AVC (2014-2016).

The AVC user inputs various cost-sharing amounts (deductible, coinsurance, OOP maximums, copays, certain copay limits) and then runs a macro to obtain the plan's calculated AV and qualifying metallic tier (or a message indicating the calculated AV is outside the de minimis range for one of the metallic tiers).

The underlying enrollment and claims data used to develop the 2014 AVC was 2010 experience data for commercial insurance plans nationwide, supplemented by separate data sources to fill in missing EHBs (e.g., pediatric vision and pediatric dental), and trended to 2014. Because plan design information was not available to the developers of the AVC, they used algorithms to impute cost sharing and then grouped plans by their implied AVs. In addition, HHS determined that, because such a small percent of total costs are incurred by non-network providers, the AVC only considers in-network services and cost sharing.

An issuer has two options if it determines the AVC doesn't appropriately handle a particular benefit design:

1. **Adjust the inputs:** Adjust the benefit design inputs to fit the parameters of the AVC.
2. **Adjust the outputs:** Use the AVC for the benefit design components that fit the parameters of the AVC and then calculate appropriate adjustments to the resulting AV for unique plan design features.

The use of either alternative requires a member of the American Academy of Actuaries to certify that the approach is in accordance with generally accepted actuarial principles and methodologies. In addition, any adjustments made to AVC inputs or outputs must exclude out-of-network benefits.

Because of limitations of the data underlying the AVC, several features common to commercial benefit plans aren't directly addressed in the AVC:

- As mentioned earlier, the AVC does not consider out-of-network benefits or cost sharing.
- The AVC does not account for the impact of family deductible limits. For plans with high deductibles and, especially, plans with aggregate family deductibles, these limits can have a material impact on AV.
- The AVC cannot accommodate outpatient surgery copays unless the user converts the copay to an effective coinsurance.
- The AVC cannot accommodate plan designs in which both a copay and coinsurance apply to prescription drug benefits.
- For services subject to the plan deductible and a service-level copay, the 2014 AVC assumed copays apply before the deductible, which is uncommon in pre-ACA benefit plans and can have a material impact on a plan's true (or pricing) AV. Note: The 2016 AVC, released in January 2015, allows the user to specify, at a service level, whether the deductible applies before or after copays.

In addition, the use of continuance tables and some of the AVC algorithms resulted in counterintuitive AV results. Many of these issues have been at least partly resolved in the 2016 AVC, as discussed below. In August 2013, the American Academy of Actuaries released an exposure draft of a *Minimum Value and Actuarial Value Determinations Under the Affordable Care Act* practice note, which provided nonbinding guidance to actuaries for handling plan designs not accommodated by the AVC. In December 2014, the Actuarial Standards Board released an exposure draft of a proposed Actuarial Standard of Practice (ASOP), *Determining Minimum Value and Actuarial Value Under the Affordable Care Act*, which addresses many of the same issues.

It is important to note that the AVC is intended to assist in the design and, more importantly, qualification of a benefit plan as bronze, silver, gold or platinum. Because the AVC inputs and calculations are simplified for this purpose, it is not intended as a pricing tool, especially because it does not consider the following variables, which can have a material impact on expected costs and, therefore, pricing:

- Contracted provider discounts
- Cost of services provided by non-network providers
- Degree of health care management
- Prescription drug formulary
- Age/gender mix
- Geographic area
- Pent-up demand
- More detailed service category splits
- More precise measurement of the impact of cost sharing on utilization of services
- Other morbidity adjustments
- Family cost-sharing limits.

2016 AVC Updates

Per 45 CFR 156.135(g), HHS can make the following changes to the AVC:

- Update the maximum amount that can be entered into the OOP Maximum field to comply with changes in the annual limit on cost sharing
- Update the continuance tables to reflect more current claims and/or enrollment data
- Annually trend the claims data when such a trend adjustment would result in an increase of no less than 5 percent
- Update the AVC algorithms to accommodate new benefit plan designs
- Update the user interface if the change would "be useful to a broad group of users" of the AVC, would not affect its function, and would be technically feasible.

HHS initially released a revised AVC for 2015 that used the same underlying continuance tables (not trended) but corrected some of the calculation algorithms that caused counterintuitive results for 2014. After soliciting feedback on the proposed 2015 AVC, HHS chose to finalize the 2014 AVC with no changes for the 2015 plan year (other than an updated annual cost-sharing limit) to minimize market disruption (i.e., to avoid benefit changes between 2014 and 2015).

In addition to increasing the OOP maximum, the 2016 AVC includes many of the algorithm changes originally proposed for 2015, including allowing the user to specify whether the deductible applies before service-level copays. In addition, the underlying claims data has been trended an additional two years to 2016 at 6.5 percent per year.[4] As a result, it is likely that many plans that qualified in one of the metallic tiers for 2014 and 2015 will need to be modified to qualify in 2016. The trending of the underlying claims data alone has been shown to produce a 1.5 to 2 percent increase in AV for many plans.

CONCLUSION

The ACA's impact on the benefit designs of health plans now offered to individuals and small groups is already evident. As the new markets continue to evolve, actuaries are becoming better at navigating the new landscape created by ACA requirements, including the critical impact of AV on health plan designs. But the changes remain dynamic and unpredictable. We continue to need the input and guidance of the actuarial profession to understand the nuances and issues involved in using the AVC. Actuaries can help health insurers meet ACA requirements and even attempt to insulate them from labor-intensive annual benefit plan updates. (For example, at present it appears that it might be efficient to design plans with an eye toward the bottom of the de minimis ranges.) As actuaries continue to work with the AVC, they should provide feedback to HHS so that the calculator continues to improve in accuracy, usefulness and appropriateness for emerging benefit designs. The Centers for Medicare and Medicaid Services (CMS) can be reached with questions and feedback related to the AVC at *actuarialvalue@cms.hhs.gov*. ■

ENDNOTES

1 Kaiser Family Foundation (Jan. 3, 2013). Essential Health Benefits (EHB) Benchmark Plans, as of January 3, 2013. State Health Facts, Retrieved Feb. 18, 2015, from *http://kff.org/health-reform/state-indicator/ehb-benchmark-plans/.*

2 Per HHS' final rule on EHBs and AV, issuers are not required to include the pediatric dental EHB in their plans if a stand-alone dental plan (SADP) is available in the exchange.

3 State-required benefits are interpreted by HHS to be "specific to the care, treatment, and services that a state requires issuers to offer to its enrollees. Therefore, state rules related to provider types, cost-sharing, or reimbursement methods" would not be included in the interpretation of state-required benefits for purposes of determining costs to defray.

4 Centers for Medicare and Medicaid Services (Jan. 16, 2015). Memo: RE: Final 2016 Actuarial Value Calculator Methodology.

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