ACA Regulations: Insurance Exchanges and EHBs

COUNCIL FOR Affordable Health Coverage

Insurance Exchanges

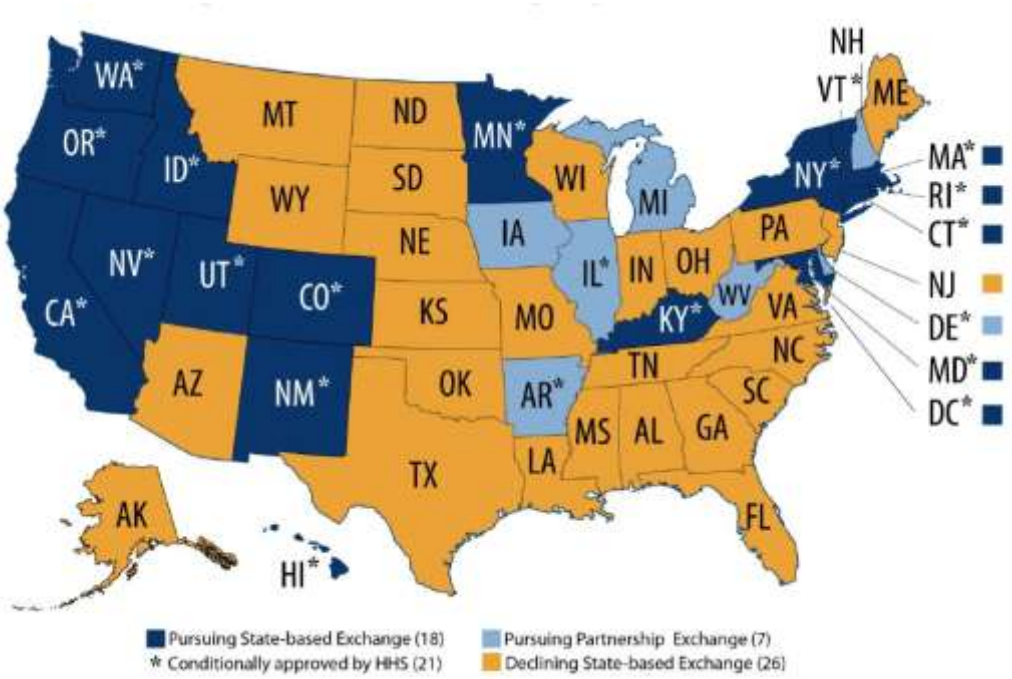
- ✓ **Insurance Exchanges:**
  - Exchanges are online marketplaces
    - More than 20 million individuals and employees of small businesses may purchase health insurance starting in October
    - Plans will be largely standardized, but consumers may choose more generous coverage (bronze, silver, gold, platinum)
  - Individuals who do not purchase coverage will likely be subject to a penalty
  - Businesses with 50+ employees who do not offer “affordable” coverage will pay a penalty
  - Open enrollment begins October 1.

- ✓ **Cost:**

  - “Pay more, get more”
  - Age rating, essential benefits, excise taxes are big factors
  - Some estimates peg premium increases at 169% for younger, healthier and minus 22% for older, sicker
  - 40 percent of people in individual market may be ineligible for subsidies

Insurance Exchanges

- The Affordable Care Act provides three options to States for insurance exchanges:
  - Run their own (18)
  - Partner with the Federal Government (7)
  - Allow the federal government to operate the exchange (26)



Insurance Exchanges

✓ **Insurance Exchanges:**

- Exchanges will vary based on availability of coverage, number and type of plans
- CBO estimates that 23 million workers will receive coverage through the individual exchanges by 2018
- Individuals with income up to 400 percent of the federal poverty level will be eligible for subsidies through exchange based plans only
- Enrollees in the Federal and in State based high risk pools will be transitioned to exchanges, likely raising costs

Final Rule: EHBs

The final rule was issued on February 20. The link to the Rule's text is **http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf**

- ✓ **The law requires health plans offered in the individual and small group markets, both inside and outside the exchanges, to be equal in scope to the benefits offered by a typical employer plan, and cover at least the following:**
  - Ambulatory patient services;
  - Emergency services;
  - Hospitalization;
  - Laboratory services;
  - Maternity and newborn care;
  - Mental health and substance use disorder services, including behavioral health;
  - Prescription drugs;
  - Preventive and wellness services and chronic disease management;
  - Rehabilitative and habilitative services and devices; and
  - Pediatric services, including oral and vision care.

- ✓ **Cost-sharing may not exceed the statutory limits, except for small group plans.**

Final Rule: EHBs

- ✓ **The rule ties essential benefits to a state's selected benchmark plan.**

- ✓ **States may choose from four benchmark options:**
  1. Largest plan by enrollment in any of the three largest small group products;
  2. Any of the largest three state employee plans by enrollment;
  3. Any of the largest three open FEHB plans by enrollment; and
  4. Largest commercial non-Medicaid HMO.

- ✓ **States have selected their benchmarks.**
  - Majority of states selected the plan from the largest small group product.

- ✓ **States may require additional benefits, but must bear the cost.**

- ✓ **Special rules:**
  - Gaps: If no coverage within a category, category is added from another option in its entirety
  - Vision: either FEDVIP Vision Plan or CHIP (with largest enrollment)
  - Dental: either FEDVIP or CHIP (with largest enrollment)
  - Habilitative: not well-defined across states. States may define for benchmark

Final Rule: EHBs

- ✓ **Plans must provide benefits that are substantially equal to the benchmark plan including:**
  - Covered benefits;
  - Limitations on coverage, including coverage of benefit amount, duration and scope;
  - Covers at least the greater of one prescription drug in each category or the same number of drugs in each category and class as the benchmark plan;
  - Parity for mental and behavioral health;
  - No cost sharing for preventive services; and
  - Procedures in place to request clinically appropriate drugs not covered by the plan.

- ✓ **Plans may substitute benefits if the substitute is:**
  - Actuarially equivalent;
  - Made within the same benefit category; and
  - Not a prescription drug benefit.

- ✓ **Plan benefits are not considered EHB if the design or implementation discriminates based on age, length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions. May use prior authorization and utilization management, however.**

Final Rule: EHBs

- ✓ **Cost Sharing:**
  - Annual limit on cost sharing tied to HSA out of pocket limit (For 2013: $6,250 individual and $12,500 family).
  - Annual limit on patient-cost sharing will not apply to services obtained through out-of-network providers
  - Concern that plans may not have an array of in-network specialists to diagnose and treat people with rare diseases

- ✓ **Small Group Deductible Cap:**
  - Law sets small group deductible maximum at $2,000 individual/$4,000 family.
  - Rule reaffirms the cap and increases the amount by premium cost growth.
  - A plan may exceed the cap if it cannot reasonably reach a level of coverage without doing so.

Actuarial Value:

- ✓ The final rule also addresses the actuarial value component of the essential health benefits, which is the percentage of the total average costs for benefits that a plan covers. In 2014, the following levels apply:
  - ✓ Bronze plan must cover 60% of all covered benefits;
  - ✓ Silver plan must cover 70%;
  - ✓ Gold plan must cover 80%; and
  - ✓ Platinum plan must cover 90%.

- ✓ The rule allows plans to be within two percentage points of the standard. For example, a silver plan, with a 70% AV standard, may have an AV between 68% - 72%.

Drug Benefits & Patient Concerns

- Plans will be required to cover at least the greater of one drug in every category and class of the United States Pharmacopeia ("USP") or the same number of drugs in each category and class as the benchmark plan in the state
  - Many rare disease treatments are not included in the USP classification system and the breadth of benchmark formularies varies from state to state
  - Many state benchmark plans require at least 2 drugs per class.
  - Medicare Part D requires plans to cover "all or substantially all" drugs in each class, which is what many patient advocates wanted.
  - Initially, HHS proposed to cover only one drug per class, but broadened their position in the EHB proposed rule released in November 2012. That language remained in the final rule.

✓ Confusion over what a "typical" drug plan looks like, and uncertainty about how plans will implement this provision/how much flexibility they have.

✓ Patient groups asked HHS to ensure that patients would have access to medically necessary drugs, even if they are not covered by a plan.
- The final rule states that a plan must have a process for this, but no details are provided. Sub-regulatory guidance will hopefully include more detailed information.

✓ Patient groups also asked HHS to ensure that plans would reliably cover new drugs that come onto the market, however there is no process for this…yet.

✓ Some concern that utilization management may result in specialty tiers or fail first strategies. Could result in increased service utilization that increases costs.

Questions?

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