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## **Essential Health Benefits Update: Proposed Regulations Implementing the ACA; and Application of the Proposed EHB Regulations to Medicaid Benchmark Plans**

By [Sara Rosenbaum](#)

### **Introduction**

On November 26, 2012, the Obama Administration published a series of proposed rules implementing many of the Affordable Care Act's (ACA) most important insurance reforms, including Health Insurance Market Rules and Rate Review (77 Fed. Reg. 70584), Nondiscriminatory Wellness Programs in Group Health Plans (77 Fed. Reg. 70620), and Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (77 Fed. Reg. 70644). In addition, the Administration issued informal guidance that add to and amplify on the provisions of the proposed rules.

This Implementation Brief Update examines the proposed rule implementing the Act's essential health benefits (EHB) provision (PPACA §1302). The proposed rule allows a 30-day comment period; comments on the proposed rule must be received by 5:00 p.m. EDT on December 26, 2012.

In addition, this Update summarizes a State Medicaid Directors (SMD) letter that accompanies the proposed EHB rule and describes the EHB rule's relationship to Medicaid coverage, including coverage for newly eligible beneficiaries as of January 1, 2014 (i.e, non-elderly low income persons with incomes under 133% FPL who are not already entitled to coverage under one of Medicaid's mandatory coverage groups).

### **Background**

PPACA §1201 amends the Public Health Service Act (at PHS §2707(a)) to establish coverage of certain "essential health benefits" as a federal requirement for all health insurance plans sold in the individual and small group markets. As of January 1, 2014, all health insurance products covered by the requirement must meet the EHB standard unless exempted by the ACA's "grandfathered" provisions (PPACA §1251, as modified by §10103 of the ACA and §2301 of the Health Care Education and Reconciliation Act).

The ACA then lays out the EHB ground rules, which are designed to mirror "typical" employer benefit plans but with certain important limitations related to the scope of covered benefit classes and special rules related to coverage for persons with serious illnesses and disabilities. First, PPACA §1302(b)(1) describes 10 basic benefit categories for which coverage must be provided: 1. ambulatory patient services; 2. emergency services; 3. hospitalization; 4. maternity and newborn care; 5. mental health and substance abuse 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; and 10. pediatric services, including oral and vision care. Mental health parity also applies to EHBs. Notably, the "habilitative" benefit category, which relates to coverage for persons with developmental disabilities and conditions, represents a class of benefits rarely

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found in a “typical” employer plan, as noted by the Institute of Medicine in its report, *Essential Health Benefits: Balancing Coverage and Cost* (<http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>).

Second, §1302(b)(2) requires that the HHS Secretary “ensure[]” that the “scope of the essential health benefits. . . is equal to the scope of benefits provided under a typical employer plan.”

Third, §1302(b)(4) sets out a series of considerations that the Secretary must adhere to in defining EHBs: (1) the EHB package must reflect an appropriate balance among the 10 categories; (2) the package must not be one in which coverage decisions, reimbursement rates, incentive programs, or benefit designs “discriminate against individuals because of their age, disability, or expected length of life”; (3) the package must take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; (4) EHBs must not be subject to denial against people’s wishes “because of age, expected length of life, present or predicted disability, degree of medical dependency or quality of life”; (5) the EHB provides for out-of-network coverage of emergency care; (6) authorization for offering stand-alone dental plans; and (7) the Secretary must issue periodic reviews of the EHB package to determine whether modifications are needed and an assessment of whether enrollees face difficulties accessing needed medical care for reasons of coverage and cost, along with an updating of the package.

Of particular note is the bar against the use of design, coverage, and payment and incentive rules that discriminate based on disability, age, or expected length of life. This provision represents the first time in federal law that the *content* of coverage has been subjected to requirements whose purpose is to assure that health plans do not discriminate based on disability. The provision represents a major departure from prior federal insurance laws, since even the Americans with Disabilities Act (ADA) does not bar discrimination in the content of insurance.<sup>1</sup> Especially common under “typical” employer plans are medical necessity coverage standards that limit coverage to conditions from which recovery can be expected, as opposed to conditions in which treatment is needed to maintain health or avert deterioration.<sup>2</sup> Also common are hard benefit limits (e.g., two prescription drugs per month) that reduce coverage below levels needed by persons with serious health conditions. Until recently, such an “improvement” standard also was used in Medicare until a settlement was reached by HHS with a nationwide class of beneficiaries that substituted a medical necessity test that assures coverage for post-acute home health and nursing home treatments needed for purposes of maintaining health or averting deterioration.<sup>3</sup>

Fourth, §1302(c) specifies requirements related to cost-sharing and link EHB cost-sharing to rules established under the Internal Revenue Code for high deductible health plans. The ACA also places statutory limits on deductibles, which are to be indexed over time. The statutory limits under the ACA

<sup>1</sup> Sara Rosenbaum and David Frankford et al., *Law and the American Health System* (Ch. 9) (Foundation Press, 2012).

<sup>2</sup> *Id.*

<sup>3</sup> *Jimmo v Sebelius* (2012). See Ken Thorpe, Assuring Post Acute Care Treatment for Medicare Beneficiaries (Health Affairs Blog, October 31, 2012) <http://healthaffairs.org/blog/2012/10/31/assuring-post-acute-care-treatment-for-medicare-beneficiaries/>.

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are \$2000 for an individual plan and \$4000 for other plans. The ACA also exempts preventive benefits from cost-sharing.

Fifth, §1302(d) establishes levels of coverage, known as “metals.” The metal levels (bronze (60%), silver (70%), gold (80%), and platinum (90%)) are expressed in terms of “actuarial value,” i.e., the percentage of total allowed costs of benefits provided under a health plan. Section 1302(d) further specifies that actuarial value is to be defined in relation to a “standard population.” The ACA also provides that in determining value, the HHS Secretary also must take into account employer contributions to health savings accounts that may be established. Section §1302(e) provides special actuarial value rules for catastrophic plans, which are available to individuals under 30, while §1302(f) authorizes the establishment of child only plans. Finally, §1302(g) provides that qualified health plans subject to the EHB requirement must pay federally qualified health centers (FQHCs) at the Medicaid prospective payment rate.

## The Proposed Regulations

The proposed regulations implement the EHB standard with the aim of assuring that health plans governed by the EHB package (whether or not sold through state exchanges) reflect the “typical employer plan in that state” and are built “on coverage that is already widely available, minimize[s] coverage disruption, and provide[s] consumers with familiar products.”<sup>4</sup> In keeping with this basic regulatory aim of a standard that mirrors the small-group employer plan market today, the proposed rules place modest emphasis on those portions of the law (i.e., scope of benefits, the meaning of non-discrimination) that are designed to temper these modifying provisions in favor of standards that emphasize the “typical” nature of EHB-governed products. The proposed rule does not amplify on the meaning of the statutory requirement that all health plans subject to the EHB standard pay FQHCs at the Medicaid PPS rate.

## Definitions (proposed 45 C.F. R. §156.20)

The proposed rule contains a series of definitions that guide the rule as a whole. Definitions are given for:

- “actuarial value”: the percentage paid by a health plan of the percentage of the total allowed costs of benefits.
- “base benchmark plan”: the plan that a state selects as the first step in designing its EHB package, or the default benchmark plan in states that do not select a base benchmark.<sup>5</sup>
- “EHB benchmark plan”: the base benchmark standardized to meet the EHB benefit requirements applicable to qualified health plans sold in the individual and small group markets.

<sup>4</sup> Public view version of the EHB rule, p. 73.

<sup>5</sup> Proposed 45 C.F.R. §156.100(a) gives states the choice of several base benchmarks: (1) the largest health plan by enrollment in any of the three largest small group insurance products in the state’s small group market; (2) any of the three largest state employee health plan benefit options; (3) any of the three largest federal employees health benefits plan (FEHBP); or (4) the state’s largest commercially insured HMO product. The default plan in a state that does not select is the largest plan by enrollment in the state’s small group market.

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- “percentage of total allowed costs of benefits”: the anticipated medical spending for EHB coverage paid by a health plan for a standard population, computed in accordance with the plan’s cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

## State Selection of Benchmark (proposed 45 C.F.R. §156.100)

The proposed rule specifies the steps in arriving at an EHB benchmark plan in each state. First, the proposal allows each state to select its own “base” benchmark (the starting point in developing the state’s EHB benchmark). In the event of non-state-selection, the proposed rule specifies the default base benchmark as the largest plan by enrollment in the largest product in the state’s small group market.

## Determination of EHBs for multi-state plans (proposed 45 C.F.R. §156.105)

The proposed rule specifies that the Office of Personnel Management (OPM) will select the benchmark for multi-state plans (multi-state plan standards still await issuance).

## EHB benchmark plan standards (proposed 45 C.F.R. §§155.170, 156.110, 156.125)

The proposed rule sets forth the 10 EHB benefit classes and describes the steps that will be taken to bring the base benchmark plan into conformance with the EHB benchmark plan. The proposed rule requires that base benchmark plans that are missing an entire EHB class (e.g., habilitative services) must be modified to include the class, using one of the other base benchmarks. In the case of pediatric vision and oral care, the proposed rule would permit supplementation using the FEHBP plan with the highest national enrollment or the standard used in a state’s separate CHIP plan with the highest enrollment. The proposed regulations allow states to apply to their EHB benchmark state health insurance benefit mandates in effect as of December 2011 without running afoul of the requirement that a state pay additional premium subsidies for benefits not considered part of the EHB benchmark. Thus, state benefit mandates in effect as of December 2011 may be included in the EHB package without penalty. The proposed rule’s Preamble notes that a state benefit mandate applicable to the QHP market would apply “in the same way they apply in the current market”, so that if a benefit mandate enacted before December 2011 applied only to the small group market, it would apply only to the Exchange small group market (i.e., the SHOP Exchange).<sup>6</sup>

In states that do not select a base benchmark plan and in which the Secretary therefore fashions a default base benchmark plan, the proposed rule sets forth the procedures the Secretary will use to convert the base benchmark into a benchmark covering all EHB classes if one or more EHB benefit class is missing from the default benchmark. The regulations are silent with respect to how the Secretary will deal with state benefit mandates in states in which she has established a default benchmark because the state has not made an election of its own.

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<sup>6</sup> Public view version, p. 14.

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The proposed rule would bar plans from including “discriminatory benefit designs that contravene the non-discrimination standard” set forth in 45 C.F.R. §156.125. This rule in turn states that

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 non-discrimination standard also references 45 C.F.R. §§200(e) and 156.225, which state as follows: 45 C.F.R. §156.200(e) Non-discrimination. A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

156.225 Marketing and Benefit Design of QHPs. A QHP issuer and its officials, employees, agents and representatives must . . . [n]ot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

The proposed rule provides no further detail on, or examples of, what discrimination in benefit design or its implementation would entail. The Preamble to the proposed rule does not specifically seek comments on what types of conduct should be considered potential evidence of discrimination.

## Provision of EHBs (proposed 45 C.F.R. §§156.115, 156.120)

The proposed rule specifies that the EHB standard is satisfied if a health plan:

- provides benefits that are “substantially equal” to the EHB benchmark including (i) covered benefits; (ii) limitations on coverage including coverage of benefit amount, duration and scope;
- provides prescription drug benefits that meet the requirements of proposed regulation 156.120, which specifies standards for prescription drug coverage;<sup>7</sup>
- adheres to mental health parity requirements;
- covers all federally required preventive benefits specified in §147.130; and
- in the case of habilitative benefits, either covers “habilitative benefits that (i) are similar in scope, amount, and duration” to benefits covered for rehabilitative services or (ii) that are determined by the issuer and reported to HHS.

Issuers of plans are permitted to substitute benefits under the proposed rule if the substitution is actuarially equivalent to the benefit being substituted and is made only within the same EHB category (e.g., one type of rehabilitative service substituted for another type). The proposed rule bars substitution of prescription drug benefits. Issuers engaging in substitution also must provide actuarial evidence to the state.

Thus, under the proposed rule, the EHB benefit packages offered by competing qualified health plans do not need to be identical to the benchmark. The proposed rule gives issuers significant latitude to design

<sup>7</sup> These standards specify “at least” the greater of one drug in every United States Pharmacopeia category and class and the same number of drugs in each category and class as the EHB benchmark plan. Abortion drugs are excepted.

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habilitative services and to substitute coverage within EHB classes, as long as issuers provide actuarial equivalence data. At the same time, however, the proposed rule bars deviations from the regulation's prescription drug coverage standards.

## Cost-sharing requirements (proposed §156.130)

The proposed rule would utilize the Internal Revenue Code high deductible plans as the standard for plans' annual limits on cost-sharing and describes the method for updating these annual limits going forward. According to the Preamble, the 2013 IRS limits on cost-sharing in high deductible health plans will be \$6250 for self-only coverage and \$12,500 for non-self only coverage.<sup>8</sup> After 2013, the adjustment will be published by the Department and will equal the percentage by which the average per capita premium for health insurance coverage in the preceding calendar year exceeds the average per capita premium in 2013.

Where deductibles are concerned, the proposed rule would give issuers the latitude to increase deductibles beyond the statutory limits set in the ACA if higher deductibles are needed to meet their plans' required actuarial value under the EHB rules. In other words, if an issuer cannot offer the level of coverage required under the EHB statute and regulations (in terms of benefit classes, compliance with non-discrimination rules and drug coverage rules, annual out-of-pocket limits, and cost sharing limits) without increasing the deductible for self-only and/or other coverage, the proposed rule would allow the issuer to do so.

The proposed rule would also allow issuers to credit out-of-pocket spending toward the annual plan deductible only when expenditures are made for in-network providers, even if an individual or family buys coverage that includes out-of-network treatment. The Preamble offers as a permissible example a plan that offers 3-tier coverage (two network tiers, with the third tier covering out-of-network services) while disallowing out-of-pocket payments for non-network providers as meeting the plan's deductible requirements, even in cases in which coverage under the three tiers is purchased.<sup>9</sup> The Department notes that this policy of disallowing out-of-pocket payments for non-network providers, even when out-of-network coverage is purchased, aligns with the Internal Revenue Code policy for high-deductible plans.<sup>10</sup>

The proposed rule also clarifies that plans must comply with the non-discrimination provisions of the law where cost-sharing is concerned, but offers no examples of what would be considered discriminatory. The proposed rule further specifies that plans must comply with the bar against cost-sharing for preventive services under 45 C.F.R. §147.130 and bars the use of utilization review and cost-sharing limitations in the case of out-of-network hospital emergency department care that are not applied to a plan's in-network providers.

<sup>8</sup> Public view version of the EHB NPRM, pp. 38-39.

<sup>9</sup> *Id.*, p. 41.

<sup>10</sup> *Id.*

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## Actuarial value (AV) calculation for determining level of coverage (proposed §156.135)

The proposed rule sets forth the process that HHS will use to determine actuarial value, allowing issuers to utilize methods other than the HHS AV Calculator when their health plan design “is not compatible” with the AV Calculator. In the case of group health plans that are linked to employer contributions to health savings accounts, the proposed rule would allow issuers to include employer contributions toward the AV total. The proposed rule specifies that beginning in 2015, state specific data will be used to determine the “standard population” against which AV is calculated.

## Levels of coverage (proposed §156.140)

The proposed rule sets for the metals levels and allows plans to vary from the standard value of the particular metals class (i.e., gold, silver, platinum, bronze) by up to 2 percentage points, which is defined as *de minimus* variation.

## Determinations of minimum value (proposed §156.145)

In determining whether an employer’s plan offers “minimum value” (MV) for purposes of determining whether a qualified individual may instead receive premium subsidies toward the cost of a QHP sold through the Exchange, the proposed rule sets forth the method that will be used to compare the employer plan to the EHB benchmark and EHB AV coverage standards.

## Application to stand-alone dental plans inside the exchange (proposed §156.150)

The proposed rule provides that stand-alone dental plans covering pediatric dental care must demonstrate to their Exchange that their cost-sharing limits are “reasonable.” The proposed rule would calculate these limits without regard to cost-sharing under the full EHB plan and without regard to the cost of out-of-network services. The proposed rule establishes an actuarial value range of between 75 percent and 85 percent.

## Accreditation of QHP issuers and accreditation timelines (proposed §§155.1045, 156.275)

The proposed rule sets forth a process for certifying additional accrediting bodies, which will accredit QHPs sold in Exchanges. The process includes publication of an application with the opportunity to provide public comment on the application.

The proposed rules allow states to establish a uniform timeline for QHP certification. In federally facilitated exchanges, QHPs without existing accreditation in the commercial, Medicaid, or exchange markets must have an accreditation scheduling plan. In the second year, QHP issuers must be accredited by a recognized accrediting entity for the same state in which the plan is offered. Prior to the fourth year, the proposed rule would require accreditation in the state in which the product is offered.



## **CMS State Medicaid Director Letter: The Relationship of the EHB Proposed Rule to the Medicaid Alternative Benefit Plans Benchmark Statute**

SMD letter 12-003, ACA #21 explains the relationship between the EHB rule and the Medicaid benchmark statute, which authorizes the use of “Alternative Benefit Plans” (ABPs). The letter is designed to guide states as they attempt to align ABP “benchmark” coverage authorized under Medicaid since 2006 with the newly applicable EHB standards.

The Medicaid ABP benchmark statute (SSA §1937) predates the ACA. Since 2006, federal Medicaid law has permitted states to modify traditional Medicaid coverage by substituting coverage equivalent to an ABP benchmark. This substitution can be made for certain traditional beneficiary populations, although elderly and disabled persons are exempt, as are certain other beneficiary groups. (Exempt groups may be offered an ABP benchmark as an option). Under the 2006 law (as further modified by the 2009 CHIPRA amendments), an ABP benchmark also must include EPSDT benefits for individuals under age 21. (Under the proposed EHB rules, the pediatric coverage standard for EHB benchmark plans sold in Exchanges classifies individuals ages 19 and younger as children).

The ACA further amends §1937 to bring ABP plans into conformity with all EHB benefit classes. In addition, the ACA applies mental health parity requirements to the newly configured ABP benchmark while preserving the EPSDT coverage standard for individuals under age 21.

The SMD letter describes the EHB alignment process that states will be expected to follow. CMS notes that the §1937 ABP benchmark standard(s) chosen by the state plus EPSDT represent the “starting point” for aligning a state’s ABP plan with EHB benchmark rules. The alignment process begins with the selection of the ABP benchmark(s), similar to the process by which a state establishes its EHB benchmark. Once the ABP benchmark (comparable to the base-benchmark plan) is selected, the state is then expected to adjust its ABP benchmark (which already has been adjusted to include the EPSDT benefit) to conform to the EHB rules. Section 1937 ABP benchmarks differ slightly from the base-benchmark plans recognized under the proposed EHB regulations and consist of the standard Blue Cross/Blue Shield preferred provider option through the FEHBP, a “generally available” state employee coverage, or the largest commercial HMO product. (In states with federally facilitated exchanges, the ABP benchmark presumably would be adjusted to conform to the FFE EHB benchmark but the SMD letter does not specifically address the Medicaid alignment process in states in which a FFE is in operation). This means the addition of specific benefit classes not contained in the ABP benchmark plus adjustments to correct for any discriminatory aspects of benefit design or plan implementation, conformity with the ACA preventive benefits standard, and coverage of out-of-network coverage for emergency department services.

The SMD notes that certain rules apply to EHB benchmark plans made available to Medicaid beneficiaries as an ABP. In the case of pediatrics, EPSDT remains the coverage standard for individuals under 21, as opposed to the (presumably) narrower class of pediatric benefits for individuals under 19 that will be

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available through QHPs sold in the Exchange.<sup>11</sup> In addition, the Medicaid EHB benchmark must adhere to mental health parity requirements and must conform to Medicaid's special §1927 prescription drug coverage standards including the Medicaid drug rebate program. CMS further notes that all other federal Medicaid provisions apply to the Medicaid EHB benchmark unless a state can "satisfactorily demonstrate that implementing such other provisions would be directly contrary to their ability to implement " an EHB-aligned §1937 ABP.

Finally, CMS notes that states may submit their (EHB-aligned) ABPs to CMS beginning in the first calendar quarter of 2013.

## Issues Raised by the Proposed Rules

As with all proposed rules, the EHB proposed rule raises many important questions for public comments.

1. Is the ACA's discrimination bar sufficiently clear? The proposed rule repeats the non-discrimination prohibition contained in the ACA but does not offer examples or further explanation. Should certain types of practices be identified as at least potentially discriminatory such that issuers and states would be expected to modify them? For example, should plans be permitted to use an "improvement" or "recovery" standard in determining the medical necessity of treatment? When, if ever, do hard limits (e.g., 4 physical therapy visits per month) constitute "discrimination" in design, or are limits that apply uniformly to all covered persons considered non-discriminatory? When are plan implementation procedures considered discriminatory? How about payment and incentivization rules?
2. Benchmark for the Territories: The proposed rule specifically seeks input on the process that should be used to determine the default base-benchmark standard for the territories (Puerto Rico, the Virgin Islands, and Guam). Is there a reason why the process should differ for the territories?
3. Cutoff date for state benefit mandate inclusion in the EHB benchmark: What is the rationale for not recognizing state benefit mandates enacted after December 2011 that fall within one or more of the EHB coverage classes? Should a state add coverage for reconstructive breast surgery following a mastectomy in the individual market, why would this mandate not be recognized if not enacted or implemented prior to the December 2011 cutoff date?
4. Applicability of state benefit mandates only to comparable markets: The proposed rule would extend state benefit mandates included in QHPs only to the markets in which they apply outside

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<sup>11</sup> The EPSDT benefit consists of a comprehensive assessment of physical and mental development, comprehensive vision, dental and hearing coverage, and all medically necessary items and services that fall within the federal definition of medical assistance, even if not covered for adults. With the addition of habilitative services as an EHB, the most notable differences between EPSDT and the pediatric EHB benefit in all likelihood would focus on hearing services, and a wide range of services and supports for children with serious physical, mental, and developmental disabilities that exceed the range of services that a commercial plan would make available as a habilitative service (e.g., personal attendant services). EPSDT services, furthermore, are exempt from normal amount, duration and scope limitations applicable to adult Medicaid services (e.g., 4 physical therapy treatments per month). Furthermore, EPSDT utilizes a special pediatric medical necessity standard that focuses on whether a treatment is necessary to provide early amelioration of a condition; this standard would encompass covered treatments needed to attain and maintain developmental health as well as treatments needed to avert deterioration. No definitive CMS documents compare standard commercial insurance benchmark products to the full EPSDT benefit.

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the QHP market. But states might previously have restricted benefit mandates to the group market precisely because their individual markets were so weak. With the advent of the Exchange system, which extends the value of group purchasing to the individual market, should states have the flexibility to extend benefit mandates previously limited to the group market into a newly strengthened individual market?

5. **Deductibles:** The proposed rule allows issuers to increase deductibles in order to maintain the actuarial value of their plans, so long as they can justify the deductible increases with actuarial data; should issuers be given this power? Should the Exchange instead make a final impartial determination as to whether deductibles must rise in order to offset higher-than-manageable cost increases that threaten the actuarial value of the EHB package? Should other alternative approaches be used to lower overall cost before plans are permitted to increase the deductible?
6. **Defining habilitative services:** Rather than defining habilitative services, the proposed rule allows plans to develop their own definition. Should an interim definition (all treatments and procedures covered as rehabilitation services) be the national standard until the Secretary or a state collects sufficient information to guide the development of a definition of this benefit class?
7. **Actuarial value:** Plans are considered to have met the AV requirements for each metals level if their value is within two percentage points of the AV benchmark (60%, 70%, 80%, 90%); should the discrepancy be as high as two percentage points on the low end?
8. **Counting out-of-network payments toward the deductible:** In situations in which individuals buy coverage that includes coverage for an out-of-network provider tier of coverage, should their out of network payments be permitted to count toward satisfaction of their annual deductibles?
9. **FQHC payments:** The EHB statute specifically addresses FQHC payment requirements as a feature of the EHB requirement. Should the final rules address how plans subject to the EHB standard will be expected to satisfy this requirement, both for FQHCs that furnish care on an in-network basis and those that do not?