



Date: May 16, 2014

Subject: Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards

Below are Frequently Asked Questions (FAQs) regarding implementation of certain health insurance market reforms and Marketplace standards established in the Affordable Care Act (ACA). Specifically, this document includes guidance on the implementation of the essential health benefits (EHB) and actuarial value (AV), guaranteed availability, minimum essential coverage, and transitional policy extensions.

Essential Health Benefits, Actuarial Value, and Cost Sharing

On February 25, 2013, the Department of Health and Human Services (HHS) published its final rule on *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* (78 FR 12834) (Final EHB Rule). This final rule establishes the standards related to the coverage of EHB and the determination of AV that are applicable to all non-grandfathered health plans offered in the individual and small group markets (inside and outside of the Marketplaces). Since the Final EHB Rule, several AV provisions have been amended in HHS Notice of Benefit and Payment Parameters for 2015 (79 FR 13744), which included the release of the 2015 AV Calculator.

1. For plans that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act, if an issuer imposes a waiting period before an enrollee can access a covered benefit, is that a violation of 45 CFR 156.125?

45 CFR 156.125 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 condition. We are concerned that waiting periods for specific benefits discourage enrollment of or discriminate against individuals with significant health needs or present or predicted disability. For example, a plan that includes a waiting period for any type of transplant would discriminate against those whose conditions make it likely that they would need a transplant: those with kidney disease, heart conditions, or similarly critical and life-threatening ailments. In addition, imposing a waiting period on an EHB could mean the issuer is not offering coverage that provides EHB as required by 45 CFR 156.115, which would be a violation of Section 2707(a) of the Public Health Service Act (PHS Act) and its

implementing regulations.¹ Therefore, with respect to plans that must provide coverage of the essential health benefit package, issuers may not impose benefit-specific waiting periods, except in covering pediatric orthodontia, in which case any waiting periods must be reasonable pursuant to §156.125 and providing EHB.

Any issuer that currently has a waiting period in its plan policy for an EHB needs to amend the policies to remove the waiting period within a reasonable timeframe of the release of this document. This clarification refers to a waiting period that is applied uniformly to a specific benefit within the plan design and not reasonable medical management.

2. When is a plan incompatible with the AV Calculator such that it would be required to use an alternative method for calculating AV?

As stated in the 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges² (2014 Letter to Issuers), the AV Calculator was designed to accommodate the vast majority of plan designs, but it is impossible for a single calculator to accommodate every type of plan design. For this reason, pursuant to 45 CFR 156.135(b), issuers with plan designs that are not compatible with the AV Calculator will need to use an alternate method to calculate AV. Section 156.135(b) provides two alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AV Calculator. Plans that use an alternative method must adhere to the regulatory requirements under 45 CFR 156.135(b).

These alternative methods are only for cases where the unique features of the plan design are not compatible with the AV Calculator. A plan design is incompatible when the use of the AV Calculator yields a materially different AV result from using the other approved methodologies. Building on the examples given in the 2014 Letter to Issuers, an example of a plan design that would not be compatible with the 2015 AV Calculator would be a plan that uses wellness incentives to set cost-sharing rates for the plan design, such as varying deductible and copayment amounts. This plan would not be compatible with the AV Calculator because the AV Calculator cannot account for varying deductible or copayment amounts.

Generally, a plan design that includes different cost sharing for services not included in the AV Calculator would be considered compatible with the AV Calculator. For example, advanced imaging is a single cost-sharing input in the AV Calculator; a plan design would not be considered incompatible because it assigns different copayment amounts to different types of imaging (e.g., MRI versus CT). Similarly, because the AV Calculator does not consider quantitative or qualitative limits, the application of limits to a particular benefit would generally not necessitate one of the alternative methods for AV calculation.

¹ Section 2707(a) reads: ““(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.— A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.”

² See 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges that can be found here: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

3. What guidance can you provide issuers in inputting their plans designs into the AV Calculator?

Issuers must always use an actuarially justifiable process when inputting their plan designs into the AV Calculator. Similar to the above examples, plans with more than four drug tiers do not necessarily require the issuer to use an alternative method, nor would the conversion of a copayment into a coinsurance rate for the AV Calculator input for Outpatient Surgery Physician/Surgical Services or Facility Fee. In the case of more than four drug tiers with a plan with two generic drug tiers where one tier has a significantly higher utilization rate, the plan could use the cost sharing from the higher utilization rate tier. Or, if the plan has two generic drug tiers with similar utilization rates, the plan could use the tier that has a higher cost sharing rate. Thus, in these cases, issuers would need to use an actuarially justifiable process for inputting these cost-sharing features, and in cases where using the AV Calculator yields a materially different AV result from using the other approved methodologies, the issuer should use an alternative method under 45 CFR 156.135(b).

To assist issuers in using the AV Calculator, the Centers for Medicare and Medicaid Services (CMS) provided additional clarification on the operation and functions of the AV Calculator in the 2015 AV Calculator User Guide.³ For example, in the AV Calculator User Guide, we explain the effect of the AV for drug deductibles where in certain circumstances increasing the drug deductible can increase AV because of the increased rate at which the annual limit on cost sharing is reached and the interaction with copayments and the medical benefits. Although efforts have been made to evaluate plans with similar deductibles on equal footing with regards to the point at which the annual limitation on cost sharing is reached, the interaction of the drug deductible with medical benefits can result in counterintuitive AV movements that may be accurate based on the impact of the higher deductible on the calculated level of the annual limit on cost sharing of the plan design. However, in these cases, issuers may also find that by using an actuarially justifiable process they may need to use an alternative method under 45 CFR 156.135(b) when accounting for their plan's drug deductible limit. Issuers should adhere to industry standards of practice when calculating AV and in pursuing an alternative method under 45 CFR 156.135(b).

4. How do student health insurance plans calculate AV since the population and benefits structure in these plan designs are generally different than the typical individual or small group market plan?

Student health insurance plans are required to adhere to the EHB package requirements under section 1302 of the ACA and section 2707(a) of the PHS Act that include providing plans at a given level of coverage, which is determined by the plan's AV. Specifically, under section 1302(d)(2), the level of coverage for a plan must be determined based on EHB provided to a standard population (and without regard to the population to which the plan may actually provide benefits). In the implementing regulation, under 45 CFR 156.135, we require issuers to use the AV Calculator to determine the level of coverage, as well as provide issuers with the option to use one of two alternate methods to calculate AV when the health plan's design

³ See 2015 AV Calculator and User Guide that can be found here:
<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-final.xlsx>

is not compatible with the AV Calculator. As is mentioned in the above question, this option is for use when the AV Calculator yields a materially different AV result from using the other approved methodologies.

Student health insurance plans generally must use the AV Calculator to calculate AV, or they may use an alternative method under 45 CFR 156.135(b) when certain unique features of the student health insurance plan design might yield a materially different AV result from using other approved methodologies. Regardless of the use of an alternative method, the issuer should start with the data in the continuance tables when making adjustments to be reflective of the standard population and must adhere to the regulatory requirements under 45 CFR 156.135(b). Student health insurance plans should not use an alternative method under 45 CFR 156.135(b) solely as a means to account for a different population. We intend to monitor this issue and will consider further guidance or rulemaking for calculating AV for student health insurance plans as needed for policy years after 2015.

Guaranteed Availability of Coverage

Under section 2702 of the PHS Act, as added by the ACA, health insurance issuers are generally required to guarantee the availability of coverage to every employer or individual in the State that applies for coverage. Section 2702(b)(1), however, states that health insurance issuers may restrict enrollment to open or special enrollment periods. The guaranteed availability regulation at 45 CFR 147.104(b) requires health insurance issuers in the individual market to provide special and limited open enrollment periods in certain circumstances, including for individuals who lose minimum essential coverage and for individuals enrolled in non-calendar year individual health insurance policies when their policy year ends in 2014.

5. Can a health insurance issuer file a plan for State approval in the individual or small group market that is intended to be offered only as a QHP in the Marketplace?

Issuers may file plans that they only market through the Marketplace to qualified individuals or the SHOP to qualified employers eligible to participate in a Marketplace, provided the marketing does not violate applicable discrimination standards, including those set forth in 45 CFR 156.125 and 45 CFR 156.225, and otherwise complies with applicable federal and state laws and regulations. However, such plans would be considered to be offered in the individual or group market, respectively, in the State. If, despite the fact that the issuer has not advertised the plan other than through the Marketplace, an individual or employer (as applicable) seeks to enroll in the plan directly with the issuer (outside the Marketplace), the issuer may instruct the individual or employer to complete enrollment through the Marketplace. However, if the individual or employer declines to enroll through the Marketplace, or is ineligible to do so, and wishes to enroll directly with the issuer, issuers of health insurance coverage subject to the guaranteed availability requirements of section 2702 of the PHS Act must accept every individual or employer in the state that applies for such coverage, unless an exception applies.

We note that form filing requirements generally are a matter of state law, and issuers should follow applicable State laws and regulations. The guaranteed availability requirements of

PHS Act section 2702 require that, to the extent a plan uses a contract that is designed to apply only for sale through a Marketplace, such contracts must also be valid for use in cases where the plan is subject to enrollment directly with the issuer (meaning outside the Marketplaces). For example, if permitted under applicable state authorities, issuers could file contracts that include alternative language that can be selected depending on whether enrollment occurs through or outside the Marketplaces.

Minimum Essential Coverage

The individual shared responsibility provision requires applicable individuals and their dependents, beginning in 2014, to have qualifying health insurance coverage (called minimum essential coverage), qualify for an exemption, or include a shared responsibility payment with the federal income tax return. Minimum essential coverage includes individual market health insurance policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

6. Are conversion policies offered to individuals losing group health insurance coverage considered to be minimum essential coverage under section 500A(f) of the Internal Revenue Code?

Yes, as long as the conversion coverage is offered by a health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act) and is an individual market policy subject to the consumer protections that apply to such coverage (notwithstanding that under section 2741(e)(2) of the PHS Act, the issuer is not deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy).

Transitional Policy Extensions

CMS has received a number of questions from States and issuers about the Extended Transition to Affordable Care Act-Compliant Policies bulletin, released March 5, 2014⁴. The extended transitional policy specified that no Federal enforcement actions would be taken with respect to issuers that elect to continue to offer certain coverage that would otherwise have to be cancelled as non-compliant with specified 2014 market reform requirements. The bulletin also encouraged States to adopt a similar non-enforcement policy. Under this policy, the coverage at issue would not be treated as out of compliance with the specified market reforms if certain specific conditions are met.

Like the March 5, 2014 bulletin, these FAQs are specifically applicable to the individual and small group markets, and large employers who renew insurance in the large group market for policy years beginning on or after January 1, 2016, and who will be redefined as of January 1, 2016 as small employers (those employers with 51-100 employees).

⁴ See Insurance Transitional Bulletin Series-Extension of Transitional Policy through October 1, 2016 at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

- 7. Would a large employer with 51-100 employees who is a large group policyholder be covered by the March 5, 2014 bulletin with respect to a renewal of its 2013 plan at its 2014 renewal date if the policy is not compliant with the provisions of the ACA that apply to the large group market?**

No. The extended transitional policy for eligible large group plans applies only to plans that an employer renews for a plan year beginning on or after January 1, 2016 and on or before October 1, 2016 – the year in which the law applies small group market rules to employers with 51 to 100 employees. Prior to January 1, 2016, all insurance coverage sold to large employers, whether they have 51-100 employees or greater than 100 employees must meet all applicable ACA requirements (note that few new requirements went into effect for such employers in 2014). The extended transitional policy is effective as of January 1, 2016 for eligible large employers with 51-100 employees that originally purchased the insurance in the large group market.

- 8. Is a large group employer who employs 51-100 employees required to remain with the same insurer between 2013 and 2016 in order to be eligible for transitional relief in 2016?**

No. A large group employer is not required to remain with the insurer from which it had coverage in 2013 in order to be eligible for the extended transitional relief in 2016 and thus may shop for alternative coverage with a different insurer. The key is that the extended transitional policy for eligible large group plans applies to the large employer plan that the employer has at the time of the renewal that will occur on or after January 1, 2016 and on or before October 1, 2016. Specifically, on January 1, 2016, employers who employ between 51-100 employees and thus will be redefined as small employers would be covered by the non-enforcement provisions in the March 5, 2014 bulletin through October 1, 2016 with respect to a large employer policy that does not conform to small employer rules if permitted by their State and offered by the health insurance issuer.

- 9. Are individual policyholders and small employers who changed carriers between October 2, 2013 and December 31, 2013 eligible for extended transitional relief?**

At the option of the States, and if permitted by the health insurance issuer, the extended transitional policy relief applies to health insurance coverage in the individual and/or small group market that renews between January 1, 2014 and December 31, 2014. However, as outlined in the March 5, 2014 extension of transitional policy bulletin, States have flexibility to limit the duration of the extended transition policy.

- 10. If an individual or small employer purchased a 2014 ACA-compliant plan, are there circumstances where the policyholder can have the 2013 plan reinstated and be eligible for the transitional policy relief?**

No. If an individual or small employer has purchased a new plan on or after January 1, 2014, the transitional policy would not apply if an individual or small employer attempted to

reinstate their previous 2013 non-ACA compliant plan.

11. Does the large employer transitional policy starting in 2016 apply to large employers with 51-100 employees who did not have health insurance coverage at the time the transitional policy extension bulletin was issued March 5, 2014, but who purchase a large employer policy after March 5, 2014 but before January 1, 2016?

Yes. The extended transitional policy in 2016 applies to large employers with 51-100 employees that purchase health insurance coverage any time before January 1, 2016.

12. Are transitional policies considered minimum essential coverage?

Yes. Since transitional policies are offered in the individual and small group markets, they are considered to be minimum essential coverage, and individuals enrolled in these plans would satisfy the individual shared responsibility requirement.