



FEDERAL REGISTER

Vol. 77

Monday,

No. 227

November 26, 2012

Part V

Department of Health and Human Services

45 CFR Parts 147, 155, and 156

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 155, and 156

[CMS-9980-P]

RIN 0938-AR03

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

AGENCY: Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This proposed rule details standards for health insurance issuers consistent with title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. Specifically, this proposed rule outlines Exchange and issuer standards related to coverage of essential health benefits and actuarial value. This proposed rule also proposes a timeline for qualified health plans to be accredited in Federally-facilitated Exchanges and an amendment which provides an application process for the recognition of additional accrediting entities for purposes of certification of qualified health plans.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (EST) on December 26, 2012.

ADDRESSES: In commenting, please refer to file code CMS-9980-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9980-P, P.O. Box 8010, Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9980-P, Mail

Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Leigha Basini at (301) 492-4307 for general information.

Adam Block at (410) 786-1698 for matters related to essential health benefits, actuarial value, and minimum value.

Tara Oakman at (301) 492-4253 for matters related to accreditation.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as

they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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Table of Contents

- I. Background
 - A. Legislative Overview
 - B. Stakeholder Consultation and Input
 - C. Structure of the Proposed Rule
- II. Provisions of the Proposed Regulation
 - A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets
 - 1. Subpart B—Requirements Relating to Health Care Access
 - B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act
 - C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges
 - 1. Subpart A—General Provisions
 - 2. Subpart B—EHB Package
 - 3. Subpart C—Accreditation
- III. Collection of Information Requirements
- IV. Regulatory Impact Analysis
- V. Regulatory Flexibility Act
- VI. Unfunded Mandates
- VII. Federalism
- VIII. Appendix A—List of Proposed EHB Benchmarks [List of Received Benchmarks: Partial]
- IX. Appendix B—Largest FEDVIP Dental and Vision Plan Options, as of March 31, 2012

Acronym List

Because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

- AV Actuarial Value
- CHIP Children's Health Insurance Program
- CMS Centers for Medicare & Medicaid Services
- DOL U.S. Department of Labor
- EHB Essential Health Benefits
- ERISA Employee Retirement Income Security Act (29 U.S.C. section 1001, et seq.)
- FDA U.S. Food and Drug Administration
- FEDVIP Federal Employee Dental and Vision Insurance Program
- FEHBP Federal Employees Health Benefits Program

HEDIS Healthcare Effectiveness Data and Information Set
 HHS U.S. Department of Health and Human Services
 HIOS Health Insurance Oversight System
 HMO Health Maintenance Organization
 HSA Health Savings Account
 HRA Health Reimbursement Account
 IOM Institute of Medicine
 IRS Internal Revenue Service
 MV Minimum Value
 NAIC National Association of Insurance Commissioners
 OMB Office of Management and Budget
 OPM U.S. Office of Personnel Management
 PHS Act Public Health Service Act
 PRA Paperwork Reduction Act
 QHP Qualified Health Plan
 SSA Social Security Administration
 SHOP Small Business Health Options Program
 The Act Social Security Act
 The Code Internal Revenue Code of 1986
 USP United States Pharmacopeia

Executive Summary: Beginning in 2014, all non-grandfathered health insurance coverage¹ in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans, and Basic Health Programs (if applicable) will be required to cover essential health benefits (EHB), which include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care, and are equal in scope to a typical employer health plan. In addition to offering EHB, these health plans will meet specific actuarial values (AVs): 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. These AVs, called “metal levels,” will assist consumers in comparing and selecting health plans by allowing a potential enrollee to compare the relative payment generosity of available plans. Taken together, EHB and AV will significantly increase consumers’ ability to compare and make an informed choice about health plans.

The Department of Health and Human Services (HHS) has provided information on EHB and AV standards in several phases. On December 16, 2011, HHS released a bulletin² (the “EHB Bulletin”), following a report from the U.S. Department of Labor (DOL) describing the scope of benefits typically covered under employer-

sponsored coverage and an HHS-commissioned study from the Institute of Medicine (IOM)³ recommending the criteria and methods for determining and updating the EHB. The EHB Bulletin outlined an intended regulatory approach for defining EHB, including a benchmark-based framework. Shortly thereafter, on January 25, 2012, HHS released an illustrative list of the largest three small group market products by state, which were updated on July 2, 2012.⁴ HHS further clarified the approach described in the EHB Bulletin through a series of Frequently Asked Questions (FAQs), released on February 17, 2012. On July 20, 2012, HHS published a final rule⁵ authorizing the collection of data to be used under the intended process for states to select from among several benchmark options to define EHB.

HHS also published a bulletin⁶ outlining an intended regulatory approach to calculations of AV and implementation of cost-sharing reductions on February 24, 2012 (the “AV/CSR Bulletin”). Specifically, HHS outlined an intended regulatory approach for the calculation of AV, de minimis variation standards, and silver plan variations for individuals eligible for cost-sharing reductions among other topics. As described in section IB of this preamble, “Stakeholder Consultation and Input,” HHS reviewed and considered comments on both the EHB and AV/CSR Bulletins in developing this proposed rule.

In addition, this rule proposes to amend 45 CFR 156.275, as published on July 20, 2012 (77 FR 42658), which established the first phase of an intended two-phase approach to recognizing accrediting entities. As directed under law, recognized entities will implement the standards established under the Affordable Care Act for qualified health plans (QHPs) to be accredited on the basis of local performance on a timeline established by the Exchange. The amendment to phase one included herein would not alter recognition of the National Committee for Quality Assurance (NCQA) and URAC on the terms outlined in the final rule (and as provided in the **Federal Register** Notice being released concurrently with this proposed rule) and would provide an

opportunity for additional accrediting entities meeting the conditions in § 156.275 to be recognized by the Secretary, until phase two is in effect. This opportunity would include an application and review process. This rule also proposes a timeline for the accreditation standard for the purposes of QHP certification in Federally-facilitated Exchanges.

I. Background

A. Legislative Overview

Section 1302 of the Affordable Care Act provides for the establishment of an EHB package that includes coverage of EHB (as defined by the Secretary of the Department of Health and Human Services (the Secretary)) and AV requirements. The law directs that EHB be equal in scope to the benefits covered by a typical employer plan and cover at least the following 10 general categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Sections 1302(b)(4)(A) through (D) establish that the Secretary must define EHB in a manner that (1) Reflects appropriate balance among the 10 categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denials of EHB based on age, life expectancy, or disability. Sections 1302(b)(4)(E) and (F) further direct the Secretary to consider the provision of emergency services and dental benefits when determining whether a particular health plan covers EHB. Finally, sections 1302(b)(4)(G) and (H) specify that the Secretary periodically review the EHB, report the findings of such review to the Congress and to the public, and update the EHB as needed to address any gaps in access to care or advances in the relevant evidence base. Section 1311(d)(3)(B) establishes that states may require a QHP to cover additional benefits beyond those in the EHB, provided that the state defrays the costs of such required benefits.

Section 1301(a)(1)(B) of the Affordable Care Act directs all issuers of QHPs to cover the EHB package described in section 1302(a) of the Affordable Care Act, including coverage of the services described in section

¹ For more information on status as a grandfathered health plans under the Affordable Care Act, please see Interim Final Rule, “Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act.” Available at: <http://ccio.cms.gov/resources/regulations/index.html#gp>.

² Available at: http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

³ “Essential Health Benefits: Balancing Coverage and Cost.” October 6, 2011. Available at: <http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>.

⁴ Available at: <http://ccio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf>.

⁵ 77 FR 42658 (July 20, 2012).

⁶ Available at: <http://ccio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>.

1302(b), adhering to the cost-sharing limits described in section 1302(c), and subject to 1302(e), meeting the AV levels established in section 1302(d). Section 2707(a) of the Public Health Service (PHS) Act extends the coverage of the EHB package to issuers of non-grandfathered individual and small group policies beginning with plan years starting on or after January 1, 2014, irrespective of whether such issuers offer coverage through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost-sharing under the plan does not exceed the limitations described in sections 1302(c)(1) and (2) of the Affordable Care Act.

Section 1302(d)(2) of the Affordable Care Act describes the levels of coverage that section 1302(a)(3) includes in the EHB package: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Section 1302(d)(3) directs the Secretary to develop guidelines that allow for de minimis variation in AV calculations.

Section 1311(c)(1)(D)(i) of the Affordable Care Act directs a health plan to “be accredited with respect to local performance on clinical quality measures * * * by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria).” Section 1311(c)(1)(D)(ii) requires that QHPs “receive such accreditation within a period established by an Exchange * * *.” In a final rule published on July 20, 2012 (77 FR 42658), because the NCQA and URAC already met the statutory requirements, they were recognized as accrediting entities on an interim basis, subject to the submission of documentation required in 45 CFR 156.275(c)(4). This recognition is now effective as indicated in a **Federal Register** notice being published concurrently with this proposed rule. In this proposed rule, HHS introduces a new process by which accrediting entities that are not already recognized can submit an application to be recognized and establishes a proposed notice and final notice process for recognizing any new accrediting entities. HHS intends, through future rulemaking, to establish a phase two recognition process which may establish additional criteria for the recognition of accrediting entities. This rule also proposes a timeline for the accreditation requirement in a Federally-facilitated Exchange.

B. Stakeholder Consultation and Input

HHS has consulted with interested stakeholders on several policies related to EHB, AV, and Exchange functions. HHS held a number of listening sessions with consumers, providers, employers, health plans, and state representatives to gather public input, and released several documents for public review and comment. As described previously, HHS released two Bulletins that outlined our intended regulatory approach to defining EHB and calculating AV and sought public comment on the specific approaches.

In addition to the listening sessions, HHS considered the findings of an IOM study, as well as a report conducted by the DOL⁷ on typical benefits offered by employer-sponsored coverage before releasing the Bulletins.

Finally, HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with states through the Exchange grant process, Medicaid consultation, and meetings with tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties.

HHS received approximately 11,000 comments in response to the EHB Bulletin. Commenters represented a wide variety of stakeholders, including health insurance issuers, consumers, health providers, states, employers, employees, and Members of Congress.

We considered all of these comments as we developed the policies in this proposed rule. Though we do not address each comment received, we discuss many of the comments throughout the proposed rule. In addition, HHS will be consulting with federally recognized tribes on the provisions of this proposed rule that impact tribes.

C. Structure of the Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 147, 155, and 156. Part 147 outlines proposed standards for health insurance issuers in the small group and individual markets related to health insurance reforms. Part 155 outlines the proposed standards for states relative to the establishment of Exchanges and outlines the proposed standards for Exchanges related to minimum Exchange functions. Part 156 outlines

the proposed standards for issuers of QHPs, including with respect to participation in an Exchange. The standards proposed to be codified in Part 156 as laid out in this NPRM apply only in the individual and small group markets, and not to Medicaid benchmark or benchmark-equivalent plans. EHB applicability to Medicaid will be defined in a separate regulation.

II. Provisions of the Proposed Regulation

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Subpart B—Requirements Relating to Health Care Access

a. Coverage of EHB (§ 147.150)

Section 2707(a) of the Public Health Service Act (PHS Act), as added by the Affordable Care Act, directs health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market to ensure that such coverage includes the EHB package defined under section 1302(a) of the Affordable Care Act that includes the coverage of EHB, application of cost-sharing limitations, and AV requirements (plans must be a bronze, silver, gold, or platinum plan or a catastrophic plan).

Section 1255 of the Affordable Care Act provides that this EHB package standard applies starting the first plan year for the small group market or policy year for the individual market beginning on or after January 1, 2014. In § 147.150(a), we propose that a health insurance issuer that offers health insurance coverage in the individual or small group market—inside or outside of the Exchange—ensure that such coverage offers the EHB package.

PHS Act section 2707(b) provides that a group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) and (c)(2) of the Affordable Care Act. Section 715(a)(1) of the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (Code) incorporates section 2707(b) of the Public Health Service Act into ERISA and the Code. HHS, DOL, and the Department of the Treasury read the limitations on the scope of section 1302(c) of the Affordable Care Act to apply also to the scope of PHS Act section 2707(b). Therefore, these deductible limitations apply only to plans and issuers in the small group market and do not apply to self-insured plans or health insurance issuers offering health insurance

⁷ “Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services.” April 15, 2011. Available at: http://www.bls.gov/ncs/ebs/sp/selmedbens_report.pdf.

coverage in the large group market. Section 147.150(b) is reserved at this time.

In addition, section 2707(c) of the PHS Act provides that an issuer offering any level of coverage specified under section 1302(d) of the Affordable Care Act offer coverage in that level to individuals who have not attained the age of 21. We propose to codify this standard in § 147.150(c). An issuer could satisfy this standard by offering the same product to applicants seeking child-only coverage that it offers to applicants seeking coverage solely for adults or for families including both adults and children, as long as the child-only coverage is priced in accordance with the applicable rating rules.

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

State Required Benefits

Section 1311(d)(3)(B) of the Affordable Care Act explicitly permits a state to require QHPs to offer benefits in addition to EHB, but requires the state to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional benefits. We propose that state-required benefits enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB, which would obviate the requirement for the state to pay for these state-required benefits. We also propose that state-required benefits that are not included in the benchmark would apply to QHP markets in the same way they apply in the current market. For example, a benefit that is only required in the individual market by a state law enacted prior to December 31, 2011 would only be considered EHB (and exempt from the requirement that the state pay the cost of the benefit) with respect to the individual QHP market in 2014. This policy regarding state-required benefits is intended to apply for at least plan years 2014 and 2015.

HHS received many comments in response to the EHB Bulletin about how state-required benefits beyond EHB could be identified and how states would defray the cost of those benefits. In this proposed rule, we interpret state-required benefits 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 fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be

no federal obligation for states to defray the costs associated with those requirements.⁸

Under the Affordable Care Act, state payment for state-required benefits only applies to QHPs. Since the Exchange is responsible for certifying QHPs, we propose that the Exchange identify which additional state-required benefits, if any, are in excess of the EHB. HHS intends to publish a list of state-required benefits for Exchanges to use as a reference tool.

After consideration of four possible entities to conduct the cost calculation for additional coverage (QHP issuers, the state, the Exchange, or HHS), we believe that the QHP issuer should conduct the calculation for the cost of additional benefits, because the QHP generates the necessary data regarding claims, utilization, trend, and other issuer-specific data typically used to calculate the cost of a benefit. Because QHP issuers will offer state-required benefits to every enrollee, the cost of the benefit will be built into the overall premium and spread across all enrollees. We believe that the best method to calculate the state's cost, if applicable, is to have the QHP issuer quantify the amount of premium attributable to each additional benefit.

We additionally propose that the calculations of the cost of additional benefits be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies. We also propose the calculation be done prospectively to allow for the offset of an enrollee's share of premium and for purposes of calculating the premium tax credit and reduced cost sharing.⁹ We request comment on whether the state should make payments based on the statewide average cost or make payments based on each QHP issuer's actual cost if different issuers report that a particular additional required benefit costs a different amount. We note that we expect there will be few, if any, payments made for state-required

⁸ For example, a state statute requiring issuers to pay the same for a physician consultation in the office and via telemedicine would not be a state-required benefit. The physician consultation is the service; the requirement to pay for telemedicine relates to payment for the service delivery method. Since the requirement addresses a specific delivery method, not the underlying care, treatment, or service being delivered, there is no requirement to defray the cost.

⁹ Section 36B1401(b)(3)(D) of the Code specifies that the portion of the premium allocable to required additional benefits shall not be taken into account in determining a premium tax credit. Likewise, section 1402(c) of the Affordable Care Act specifies that cost-sharing reductions do not apply to required additional benefits.

benefits since required benefits enacted prior to December 31, 2011 will be part of EHB, and therefore will not require the state to incur any costs.

Accreditation Timeline (§ 155.1045)

HHS proposes to amend § 155.1045 to redesignate the existing paragraph as paragraph (a) and add a new paragraph (b) to set forth the timeline for QHP accreditation in Federally-facilitated Exchanges (including State Partnership Exchanges). HHS proposes a phased approach to the requirement that QHP issuers be accredited in Federally-facilitated Exchanges. This approach is in part modeled after the one used by some states that require accreditation as part of issuer licensing. Further, this approach will accommodate new issuers—including Consumer Operated and Oriented Plans—and those that have not previously been accredited, while ensuring that all QHP issuers make a commitment to ensure the delivery of high quality care to consumers.

The proposed accreditation timeline to be used in Federally-facilitated Exchanges is as follows:

- During certification for an issuer's initial year of QHP certification (for example, in 2013 for the 2014 coverage year), a QHP issuer without existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is applying to offer coverage must have scheduled or plan to schedule a review of QHP policies and procedures of the applying QHP issuer with a recognized accrediting entity.
- Prior to a QHP issuer's second year and third year of QHP certification (for example, in 2014 for the 2015 coverage year and 2015 for the 2016 coverage year), a QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products or, a QHP issuer must have commercial or Medicaid health plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP.
- Prior to a QHP issuer's fourth year of QHP certification and in every subsequent year of certification (for example, in 2016 for the 2017 coverage year and forward), a QHP issuer must be accredited in accordance with 45 CFR 156.275.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Subpart A—General Provisions

In § 156.20, we propose to add definitions as follows:

Actuarial Value and Percentage of the Total Allowed Costs of Benefits

We propose to define “AV” as the percentage paid by a health plan of the total allowed costs of benefits (using the term “percentage of the total allowed costs of benefits” that we also propose to define here).

In general, AV can be considered a general summary measure of health plan generosity. We propose to define the “percentage of the total allowed costs of benefits” as the anticipated covered medical spending for EHB coverage (as defined in § 156.110 (a)) paid by a health plan for a standard population, computed in accordance with the health plan’s cost sharing, divided by the total anticipated allowed charges for EHB coverage provided to the standard population, and expressed as a percentage.

Because section 1302(d)(2) of the Affordable Care Act refers to AV relative to coverage of the EHB for a standard population, we propose these definitions together in order to provide that AV is the percentage that represents the total allowed costs of benefits paid by the health plan, based on the provision of EHB as defined for that plan according to § 156.115.

Benchmark Plans

Under the benchmark selection and standards proposed in § 156.100 and § 156.110, we believe it is important to differentiate between the plan selected by a state (or through the default process in § 156.100(c)), which we are proposing to call the “base-benchmark plan,” and the benchmark standard that EHB plans will need to meet, which we are proposing to call the “EHB-benchmark plan.”

We propose that “base-benchmark plan” means the plan that is selected by a state from the options described in § 156.100(a), or a default benchmark plan, as described in § 156.100(c), prior to any adjustments made to meet the benchmark standards described in § 156.110.

We propose that “EHB-benchmark plan” means the standardized set of EHB that must be met by a QHP or other issuer as required by § 147.150.

We propose that “EHB package” means the scope of covered benefits and associated limits of a health plan offered

by an issuer, as set forth in section 1302(a) of the Affordable Care Act. The EHB package provides at least the ten statutory categories of benefits, as described in § 156.110(a); provides benefits in the manner described in § 156.115; 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.

2. Subpart B—EHB Package

a. State Selection of Benchmark (§ 156.100)

In § 156.100, we propose criteria for the selection process if a state chooses to select a benchmark plan. As we note in § 156.20, the plan selected by a state is known as the base-benchmark plan. After the application of any adjustments described in § 156.110, the plan will be known as the EHB-benchmark plan. The EHB-benchmark plan would apply to non-grandfathered health insurance coverage offered in the individual or small group markets. The EHB-benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state. This approach and benchmark selection, which would apply for at least the 2014 and 2015 benefit years, would allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products. This approach is intended to balance consumers’ needs for comprehensiveness and affordability, as recommended by IOM in its report on the EHB.¹⁰ In developing these proposed guidelines, we considered the comments on the EHB Bulletin, which urged an open and transparent benchmark selection process with an opportunity for public input.

Consistent with the approach outlined in the EHB Bulletin, we propose in § 156.100(a) that the state may select its base-benchmark plan from among four types of health plans. These are (1) The largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market as defined in § 155.20; (2) any of the largest three state employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment that are open to Federal employees; or (4) the largest insured commercial non-

Medicaid Health Maintenance Organization (HMO) operating in the state. As we discussed in the EHB Bulletin, we use enrollment data from the first quarter two years prior to the coverage year to determine plan enrollment. To help states make their benchmark selections, HHS has provided states with benefit data on the largest plans by enrollment in the three largest small group insurance products in each state’s small group market as of the first quarter of calendar year 2012.¹¹ States can use that information, which we collected from issuers through HealthCare.gov, to inform their EHB benchmark selections. In addition to the data available on HealthCare.gov for insurance products in the states’ small group markets, in Appendix B, HHS is also making available benefit data for the single largest Federal Employees Dental and Vision Insurance Program (FEDVIP) dental and vision plans respectively, based on enrollment.

Proposed paragraph (a)(1) of § 156.100 would reflect a typical plan in the state’s small group market and provide state flexibility as recommended by the IOM in its report.¹² The remaining proposed benchmark plan options, in paragraphs (a)(2) through (a)(4), reflect the benchmark approach in Medicaid defined in 42 CFR 440.330 and in the Children’s Health Insurance Program (CHIP) in 42 CFR 457.410 and 457.420. We believe these options reflect both the scope of services and any limits offered by a “typical employer plan” as specified by section 1302(b)(2)(A) of the Affordable Care Act. Based on commenters’ requests for an open and transparent selection process, we encourage states to solicit public input prior to their selection and confirmation of a state benchmark plan.

We believe that our proposed approach and the benchmark options available to states for defining EHB best reflect the balance between comprehensiveness, affordability, and state flexibility as recommended by the IOM.

Because the PHS Act defines “state” to include the U.S. territories (Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands), the EHB requirements established by section 1302 of the Affordable Care Act apply to the territories. Given the smaller size and unique nature of the territories’ health insurance markets, we seek comment as to whether the benchmark default

¹¹ <http://ccio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf>.PDF

¹⁰ Institute of Medicine, “Essential Health Benefits: Balancing Coverage and Cost” (2011).

¹² Institute of Medicine, “Essential Health Benefits: Balancing Coverage and Cost” (2011).

process described in proposed § 156.100(c) is appropriate for the territories. In particular, we seek comment as to whether the default base-benchmark plan that will apply to the states—the largest plan by enrollment in the largest product in the state's small group market—is an appropriate default base-benchmark plan for the territories; or whether one of the other four types of health plans outlined in the EHB Bulletin, such as the largest FEHBP plan, would provide a more appropriate default base-benchmark. We note that the territories have the same opportunity as states to select a benchmark plan and we encourage them to do so.

In Appendix A: List of Proposed EHB Benchmarks, we provide a list of proposed benchmarks either selected by states or, for states that have not selected, we propose what the default benchmark plan would look like if the benchmark was determined by the Secretary in accordance with § 156.100(c). States were encouraged to submit their selections by October 1, 2012 to serve as the benchmarks for 2014 and 2015. If a state wishes to make a selection or change its previous selection it must do so by the end of the comment period of this proposed rule. Pending publication of a final rule, we are proposing that the default benchmark option will apply in cases where a state does not voluntarily select a benchmark. Issuers have commented that early selection is important to provide them with sufficient time to develop and receive certification for QHPs in advance of the QHP application review scheduled for early 2013.

At § 156.100(b), we propose the standard for approval of a state-selected EHB-benchmark plan. Section 156.100(b) specifies that to become an EHB-benchmark plan, a base-benchmark plan must meet the specifications in § 156.110, which include, coverage of at least the 10 categories of benefits outlined in the Affordable Care Act.

Sections 1302(b)(4)(G) and (H) of the Affordable Care Act direct the Secretary to periodically review the definition of EHB, report the findings of such review to the Congress and the public, and update the EHB definition as needed to address gaps in access to care or advances in the relevant evidence base. In response to the EHB Bulletin, we received different comments from stakeholders on the frequency with which updates to the EHB should occur. Some commenters favored annual updates, while others recommended less frequent updates, including initially waiting until 2016 or 2017. We propose

that the state's benchmark plan selection in 2012 would be applicable for the 2014 and 2015 benefit years, and be based on plan benefits offered by the selected benchmark at the time of selection, including any applicable state-required benefits enacted prior to December 31, 2011. We intend to revisit this policy for subsequent years. We chose this approach for establishing a consistent set of benefits for two years in order to directly reflect current market offerings and limit market disruption in the first years of the Exchanges. We invite comment on the process that HHS should use to update EHB over time.

We intend to use the enforcement processes and standards established in 45 CFR part 150 to ensure that plans adhere to the EHB standards incorporated under the PHS Act. Part 150 sets forth HHS's enforcement processes under sections 2723 and 2761 of the PHS Act, with respect to the requirements of title XXVII of the PHS Act. Section 2723 generally provides that states have primary enforcement authority over health insurance issuers, but allows HHS to take enforcement actions against issuers in a state if a state has notified HHS that it has not enacted legislation to enforce or that it is not otherwise enforcing, or when HHS has determined that a state is not substantially enforcing one or more provisions of part A of title XXVII of the PHS Act. HHS may also take direct enforcement action against issuers in a state if HHS determines, pursuant to the process set forth in 45 CFR part 150, that a state is not substantially enforcing a provision of part A of title XXVII of the PHS Act. This enforcement authority is extended through section 1321(c)(2) of the Affordable Care Act to apply to enforcement of the requirements under title I of the Affordable Care Act, including section 1302.

In § 156.100(c), we propose that if a state does not make a selection using the process defined in this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product in the state's small group market.

b. Determination of EHB for Multi-State Plans (§ 156.105)

In § 156.105, we propose an alternative way of complying with the EHB requirement for multi-state plans offered under contract with U.S. Office of Personnel Management (OPM) pursuant to section 1334 of the Affordable Care Act. We propose that multi-state plans must meet benchmark standards set by OPM, which will promulgate forthcoming regulations and

guidance related to its Multi-State Plan Program (MSPP).

c. EHB Benchmark Plan Standards (§ 156.110)

Many commenters urged HHS to establish standards or a process to ensure that an EHB-benchmark plan contains all 10 statutory EHB categories, reflects an appropriate balance among the categories, and is non-discriminatory. In addition, a number of commenters suggested factors for consideration in selecting an EHB-benchmark plan, including plan comprehensiveness, affordability, administrative simplicity, evidence-based practice, ethics, population health, inclusion of value-based insurance design, and continuity of coverage.

To clarify the relationship between the 10 statutory categories and the EHB-benchmark plan, in paragraph (a) we propose that the EHB-benchmark plan must provide coverage of at least the following categories of benefits described in section 1302(b)(1) of the Affordable Care Act: (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; and (10) pediatric services, including oral and vision care.

With respect to the tenth category, we interpret "pediatric services" to mean services for individuals under the age of 19 years. Several states have asked HHS to define the age for coverage of "pediatric services" to ensure comprehensive and consistent treatment in every state. This interpretation is consistent with the age stated in the Affordable Care Act's prohibition on preexisting conditions for children, and the age limit for eligibility to enroll in the CHIP. While we recommend coverage of pediatric services up to age 19, states have the flexibility to extend pediatric coverage beyond the proposed 19 year age limit.

Since some base-benchmark plan options may not cover all 10 of the statutorily required EHB categories, in paragraph (b), we propose standards for supplementing a base-benchmark plan that does not provide coverage of one or more of the categories described in paragraph (a). In paragraph (b)(1), we propose that if a base-benchmark plan option does not cover any items and services within an EHB category, the base-benchmark plan must be

supplemented by adding that particular category in its entirety from another base-benchmark plan option. The resulting plan, which would reflect a base-benchmark that covers all 10 EHB categories, would be required to meet standards for non-discrimination and balance defined in paragraphs (d) and (e) of this section. After meeting all of these requirements, it would be considered the EHB-benchmark plan.

In paragraphs (b)(2) and (b)(3), we discuss two categories of benefits that may not currently be included in some major medical benefit plans, but which will be included in the EHB defined in § 156.110(a), based on section 1302(b)(1) of the Affordable Care Act. In our review of research on employer-sponsored plan benefits, including small employer products, HHS found that a number of potential benchmarks do not include coverage for pediatric oral and vision services, as they are often covered under stand-alone policies. To address these gaps, we propose targeted policy options for each of these benefit categories.

In paragraph (b)(2), we provide states with two options for supplementing base-benchmark plans that do not include benefits for pediatric oral care coverage. The first option, described in paragraph (b)(2)(i), is to supplement with pediatric coverage included in the FEDVIP dental plan with the largest enrollment. The second option, described in paragraph (b)(2)(ii), is to supplement with the benefits available under that state's separate CHIP program, if applicable.

Similarly, in paragraph (b)(3), we propose that if the base-benchmark plan does not include pediatric vision services, then these benefits may be supplemented from one of two options. The first option, described in (b)(3)(i), is to supplement pediatric vision coverage included in the FEDVIP vision plan with the largest national enrollment offered to Federal employees under 5 U.S.C. 8982. The second option, described in (b)(3)(ii), is to supplement pediatric vision coverage with the state's separate CHIP plan, if applicable. We believe that this additional option—an expansion of the policy presented in the EHB Bulletin—will provide states with valuable flexibility as they select their EHB benchmark plans. HHS will make benefit data available to facilitate any supplementation by states of their base-benchmark plans with benefits from FEDVIP dental and vision plans prior to the publication of this final rule.

In paragraph (c), we propose the process by which HHS would supplement a default base-benchmark plan, if necessary. We clarify that to the

extent that the default base-benchmark plan option does not cover any items and services within an EHB category, the category must be added by supplementing the base-benchmark plan with that particular category in its entirety from another base-benchmark plan option. Specifically, we propose that HHS would supplement the category of benefits in the default base-benchmark plan with the first of the following options that offer benefits in that particular EHB category: (1) The largest plan by enrollment in the second largest product in the state's small group market as defined in § 155.20; (2) the largest plan by enrollment in the third largest product in the state's small group market as defined in § 155.20; (3) the largest national FEHBP plan by enrollment across states that is described in and offered to Federal employees under 5 U.S.C. 8903; (4) the plan described in paragraph (b)(2)(i) to cover pediatric oral care benefits; (5) the plan described in (b)(3)(i) to cover pediatric vision care benefits; and (6) habilitative services as described in § 156.110 (f) or § 156.115(a)(4).

In paragraph (d), we propose that the EHB-benchmark plan must not include discriminatory benefit designs. As set forth in § 156.125, those standards would prohibit benefit and network designs that discriminate on the basis of an individual's medical condition, or against specific populations as described in the statute. This proposed standard would apply both to benefit designs that limit enrollment, and those that prohibit access to care for enrollees. While we believe that it is unlikely that an EHB-benchmark plan will include discriminatory benefit offerings, this section proposes that any EHB-benchmark plan that does include discriminatory benefit designs must be adjusted to eliminate such discrimination in benefit design.

In paragraph (e), we propose implementing section 1302(b)(4) of the Affordable Care Act by proposing that the EHB-benchmark plan be required to ensure an appropriate balance among the categories of EHB so that benefits are not unduly weighted toward any category. We solicit comments on potential approaches to ensuring that the EHB-benchmark plans do not include discriminatory benefit designs and reflect an appropriate balance among the categories of EHB. In conducting research on employer-sponsored plan benefits and state-required benefits, HHS found that many health insurance plans do not identify habilitative services as a distinct group

of services.¹³ Accordingly, we are proposing a transitional policy for coverage of habilitative services that would provide states with the opportunity to define these benefits if not included in the base-benchmark plan. Specifically, in paragraph (f), we propose that in order to define EHB, if the base-benchmark plan does not include coverage of habilitative services the state may determine the services included in the habilitative services category. We believe that this transitional policy—which provides states with additional flexibility beyond what was initially outlined in the EHB Bulletin will provide a valuable opportunity for states to lead the development of policy in this area and welcome comments on this proposed approach to providing habilitative services. If states choose not to define the habilitative services category, plans must provide these benefits as defined in § 156.115.

Because states may propose benchmarks in formal comments on this proposed rule other than those tentatively proposed, HHS is requesting public comment on all possible EHB-benchmark plans, not just those included in Appendix A as proposed benchmarks. This would also include each potential base-benchmark plan available to a state for selection and all potential combinations of benefits used to supplement the base-benchmark plans to ensure coverage of at least the 10 statutory benefit categories as set forth in § 156.110. As an example, a state may select its largest small group product and, if the product is missing maternity coverage and pediatric dental coverage, supplement for missing maternity coverage with the second largest small group market product and for pediatric dental coverage with the state's CHIP dental plan. However, according to the process described in proposed § 156.110, the state may choose to supplement using the maternity benefit from any of the base-benchmark plan options in the state that offer maternity coverage, and the pediatric dental benefit from either FEDVIP or CHIP dental. In this example, commenters should consider: the state-selected EHB-benchmark plan as supplemented, the state-selected plan with other permissible supplementing options, and all other base-benchmark plans the state has the opportunity to

¹³ ASPE Research Brief, "Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans." December 16, 2011. Available at: <http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml>.

select, as supplemented by any of the options available to that state.

d. Provision of EHB (§ 156.115)

In paragraph (a)(1), we propose that plans may have limitations on coverage that differ from the EHB-benchmark plan, but covered benefits must remain substantially equal to those covered by the EHB-benchmark plan. This standard applies to the covered benefits, limitations on coverage (including limits on the amount, duration, and scope of covered benefits), and prescription drug benefits that meet the requirements of § 156.120.

As previously noted, the Affordable Care Act identifies coverage of mental health and substance use disorder benefits as one of the 10 statutory benefit categories, and therefore as an EHB for non-grandfathered health insurance coverage in both the individual and small group markets. In paragraph (a)(2), under our authority to define EHB, we propose that in order to satisfy the requirement to offer EHB, mental health and substance use disorder services, including behavioral health treatment services required under § 156.110(a)(5), must be provided in a manner that complies with the parity standards set forth in § 146.136 of this chapter, implementing the requirements under the Mental Health Parity and Addiction Equity Act of 2008.

In paragraph (a)(3), we further propose that a plan does not provide EHB unless it provides all preventive services described in section 2713 of the PHS Act, as added by section 1001 of the Affordable Care Act. As codified in § 147.130, PHS Act section 2713 requires all non-grandfathered group health plans and non-grandfathered individual and group market plans that are not exempt from the coverage requirement to offer certain preventive services without cost-sharing. We believe it is appropriate to include a requirement for coverage of these services under the definition of EHB. Setting forth this explicit application of PHS Act section 2713 in regulation is necessary because EHB-benchmark plan benefits are based on 2012 plan designs and therefore could be based on a grandfathered plan not subject to PHS Act section 2713.

As an alternative to the transitional approach outlined in § 156.110(f), some states may prefer to provide issuers with the opportunity to define the specific benefits included in the habilitative services category if it is missing from the base-benchmark plan. Accordingly, we are proposing that a state may allow issuers time and experience to define these benefits. Specifically, in paragraph

(a)(4), we propose that if the EHB-benchmark plan does not include coverage for habilitative services and the state does not determine habilitative benefits, a health insurance issuer must either: (1) Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (2) Decide which habilitative services to cover and report on that coverage to HHS. With regard to option (2), HHS intends to evaluate the habilitative services reported and further define habilitative services in the future. The issuer only has to supplement habilitative services when there are no habilitative services at all offered in the base benchmark plan and the state has not exercised its option to define habilitative services under § 156.110(f). We believe that this alternative approach would provide a valuable window of opportunity for review and development of policy in this area and welcome comments on this proposed approach.

We first introduced the concept of benefit substitution in the EHB Bulletin, which suggested that a plan offering the EHB could substitute a benefit or set of benefits for another benefit or set of similar benefits subject to certain constraints—for example, that the two sets of benefits be actuarially equivalent. In this proposed rule, we propose this policy for the substitution of benefits relative to the benefits defined by the EHB benchmark plan consistent with what HHS outlined in the EHB Bulletin. As outlined in paragraph (b)(1)(i), we propose that issuers may substitute benefits, or sets of benefits, that are actuarially equivalent to the benefits being replaced. We further propose in paragraph (b)(1)(ii) that substitution of benefits would be allowed in each of the 10 statutorily required benefit categories, meaning that substitution could only occur within benefit categories, not between different benefit categories. In paragraph (b)(1)(iii), we clarify that our proposed benefit substitution policy does not apply to prescription drug benefits. In paragraph (b)(2), we outline standards for an actuarial certification that must be submitted by an issuer to a state, which demonstrates that any substituted benefit, or group thereof, is actuarially equivalent to the original benefit or benefits contained in the EHB-benchmark for that state. Specifically, we propose that the report must: (i) Be conducted by a member of the American Academy of Actuaries; (ii) based on an analysis performed in accordance with generally accepted actuarial principles

and methodologies; and (iii) use a standardized plan population. Lastly, in paragraph (b)(3), we propose that actuarial equivalence of benefits be determined based on the value of the service without regard to cost-sharing, as cost sharing will be considered in the actuarial value calculation described in § 156.135. We note that the resulting plan benefits would be subject to requirements of non-discrimination described in § 156.125. In addition, we clarify that under this approach, states have the option to enforce a stricter standard on benefit substitution or prohibit it completely. With the exception of the EHB category of coverage for pediatric services, a plan may not exclude an enrollee from coverage in an entire EHB category covered by the plan. For example, a plan may not exclude dependent children from the category of maternity and newborn coverage.

In response to our proposed approach to benefit substitution, we seek additional comment on the tradeoff between comparability of benefits and opportunities for plan innovation and benefit choice.

In paragraph (c), we propose to clarify that a plan does not fail to provide the EHB solely because it does not offer the services described in § 156.280(d). Here we extend the statutory provision in section 1303(b)(1)(A), that allows a QHP to meet the standards for EHB even if it does not offer the services described in § 156.280(d), to health insurance issuers that offer non-grandfathered coverage in the individual or small group market. We note that this provision applies to all section 1303 services, including pharmacological services.

In paragraph (d), we propose that an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, and long-term/custodial nursing home care benefits as EHB. As previously noted, section 1302 of the Affordable Care Act requires that the EHB package include at least the 10 statutorily required categories of EHB, and be equal to the scope of benefits provided under a typical employer plan. In contrast with the benefits covered by a typical employer health plan, non-pediatric dental services, non-pediatric eye exam services, cosmetic orthodontia, and long-term/custodial nursing home care benefits often qualify as excepted benefits.¹⁴ Pursuant to the direction provided in section 1302 to define benefits equal in scope to a

¹⁴ For more information on excepted benefits, see 26 CFR 54.9831-1, 29 CFR 2590.732, 45 CFR 146.145, and 45 CFR 148.220.

typical employer plan, we propose that issuers of plans offering EHB may not include these benefits as EHB. We solicit comment on the exclusion of these specific benefits from EHB coverage.

e. Prescription Drug Benefits (§ 156.120)

In the EHB Bulletin, we indicated that we were considering an option under which, in order to be considered substantially equal to the EHB-benchmark plan, issuers would be required to cover at least one drug in each category and class in which the EHB-benchmark plan covered at least one drug. The specific drugs on each plan's drug list could vary under this approach, as long as a drug in each category and class was covered.

In response to the EHB Bulletin, a large number of commenters raised concerns about the comprehensiveness of prescription drug benefits under this potential approach. Specifically, many commenters indicated that a requirement to offer one drug per category and class could result in insufficient access to medications for individuals with certain conditions. Several commenters additionally recommended that the definition of EHB adopt the standards used in Medicare Part D, including the protected class policy under which all drugs in certain classes must be covered.¹⁵ Conversely, other commenters emphasized the importance of flexibility for issuers to design a drug benefit that maximizes value for consumers. Based on these comments and the need to balance access with affordability, we propose the following approach, on which we solicit comment.

In paragraph (a)(1) we propose that in order to comply with the requirement to cover EHB, a plan would cover at least the greater of: (1) One drug in every category and class; or (2) the same number of drugs in each category and class as the EHB-benchmark plan. As such, if the EHB-benchmark drug list offers more than one drug in a category or class, then plans covering EHB would offer at least the number of drugs in the EHB-benchmark plan for that class. Research suggests that this is consistent with coverage in the small group market today: one study found that most existing small group plans cover more than one drug in each class.¹⁶ In paragraph (a)(2) we propose that a QHP

¹⁵ CMS has identified certain "protected categories and classes." In those protected categories and classes, Plan D formularies must include substantially all drugs that are FDA-approved.

¹⁶ Available at: http://www.avalerehealth.net/pdfs/Avalere_EHB_Formulary_Analysis.pdf.

must report its drug list to the Exchange, an EHB plan operating outside of the Exchange must report its drug list to the state, and a multi-state plan must report its drug list to OPM. In paragraph (b) we clarify that a health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs that are § 156.280(d) services.

We are considering using the most recent version of the United States Pharmacopeia's (USP) classification system as a common organizational tool for plans to report drug coverage because it is publically available, widely used, and comprehensive. A classification system functions as an organizational tool, similar to an outline or taxonomy. Directing plans to submit their drug list using the same classification system would facilitate review, analysis, and comparison of the number of drugs on the QHP's list to the number of drugs on the EHB Benchmark Plan's list. If adopted in the final rule, we will continue to assess the need for and value of such a tool and intend to work with states and the NAIC to facilitate state use of the USP classification system as a comparison tool.¹⁷

In general, each EHB plan would be able to cover different drugs than are covered by the EHB-benchmark plan, but those drugs must be presented using the USP classification system. This approach permits plan flexibility in the drug benefit design and the use of medical management tools, while ensuring that plans offer drug coverage consistent with that of the typical employer plan. An EHB plan would be able to cover any drugs subject to meeting the minimum number per category and class.

We also propose that drugs listed must be chemically distinct.¹⁸ For example, offering two dosage forms or strengths of the same drug would not be offering drugs that are chemically distinct. Offering a brand name drug and its generic equivalent is another example of drugs that are not chemically distinct.

In paragraph (c), we propose that a plan offering EHB have procedures in place to ensure that enrollees have access to clinically appropriate drugs that are prescribed by a provider but are

¹⁷ The requirement to use USP classification applies only to submission of formulary for review/certification. Plans may continue to use any classification system they choose in marketing and other plan materials.

¹⁸ The concept of chemically distinct is also described in the Medicare Part D Manual, Chapter 6, Section 30.2.1. More information is available at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Chapter6.pdf>.

not included on the plan's drug list, which is consistent with private plan practice today. We solicit comments on this proposed requirement.

As discussed below, § 156.125 implements section 1302(b)(4)(B) of the Affordable Care Act, which directs the Secretary to ensure that EHBs are not designed in a discriminatory manner. In implementing § 156.125 in the context of prescription drug benefits, we encourage states to monitor and identify discriminatory benefit designs, or the implementation thereof and to test for such discriminatory prescription drug benefit designs. We will use information on complaints and appeals and data on drug lists to refine our prescription drug benefit review policy for future years.

f. Prohibition on Discrimination (§ 156.125)

Section 1302(b)(4) of the Affordable Care Act directs the Secretary to address certain standards in defining EHB, including elements related to balance, discrimination, the needs of diverse sections of the population, and denial of benefits. Section 1302(b)(4)(B) of the Affordable Care Act provides that the Secretary ensure that in terms of the benefits covered, payment rates provided, or incentives built into the definition of EHB, there is no discrimination based on age, disability, or expected length of life. Similarly, section 1302(b)(4)(C) of the Affordable Care Act provides that the Secretary take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. In addition, section 1302(b)(4)(D) of the Affordable Care Act provides that the Secretary ensure that the EHB not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life, or of the individuals' present or predicted disability, degree of medical dependency, or quality of life. Taken collectively, we interpret these provisions as a prohibition on discrimination by issuers. To inform the development of the policy on discrimination in the EHB, we sought stakeholder feedback, and considered guidance provided by the IOM. Many commenters expressed concern about the potential for benefit designs that might discriminate against certain populations or consumers with significant health needs. Commenters also recommended that HHS establish an explicit non-discrimination policy for benefit design. Based on this information, in § 156.125, we propose an approach to addressing discrimination that would allow states

to monitor and identify discriminatory benefit designs, or the implementation thereof. Under this approach, consistent with section 1563(d) of the Affordable Care Act, we would not prohibit issuers implementing the EHB standards from applying utilization management techniques. However, issuers could not use such techniques to discriminate against certain groups of people. For example, an issuer could use prior authorization, but could not implement prior authorization in a manner that discriminates on the basis of factors including age, disability, or length of life (for example, in terms of whether prior authorization is required, or when authorization is granted).

To address potentially discriminatory practices, based on the authority in section 1302(b)(4) of the Affordable Care Act, we propose in paragraph (a) 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, or present or predicted disability, degree of medical dependency, quality of life, or other health conditions. In paragraph (b), we reiterate that § 156.200 and § 156.225 also apply to plans providing EHB. Section 156.200 prohibits discrimination based on factors including but not limited to race, disability, and age. Section 156.225 prohibits marketing practices and benefit designs that result in discrimination against individuals with significant or high cost health care needs.

This proposal is intended to develop the framework for analysis tools to facilitate testing for discriminatory plan benefits. The IOM, in its report on the EHB, suggests that states have an important role in monitoring to ensure that issuers' plans do not contain outlier practices that would undermine EHB coverage. We believe that discrimination analyses could include evaluations to identify significant deviation from typical plan offerings including unusual cost sharing and limitations for benefits with specific characteristics. We also note that Medicare Advantage Program cost-sharing designs are subjected to this type of analysis for potential discriminatory effects. We welcome comments on our proposed approach to prohibiting discriminatory benefit design.

g. Cost-Sharing Requirements (§ 156.130)

Section 1302(c)(1) of the Affordable Care Act identifies an annual limitation on enrollee cost sharing. Section 1301(a)(1)(B) of the Affordable Care Act

requires all qualified health plans to comply with these limits, and section 2707(a) of the Public Health Service Act requires compliance by issuers offering non-grandfathered health insurance coverage in the individual and small group markets. Standards proposed here, at § 156.130, would be applicable to QHPs pursuant to 45 CFR 156.200(b)(3), which requires QHPs to offer the essential health benefits package described at section 1302(a) of the Affordable Care Act. Similarly, these standards would be applicable to health insurance coverage offered by health insurance issuers in the individual and small group markets pursuant to § 147.150 of these regulations, as discussed earlier.

Cost sharing is defined in § 156.20 as any expenditure required by or on behalf of an enrollee with respect to essential health benefits. The term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services. We discuss here the implications and rationale of setting these standards in the context of their application to QHPs and issuers of health plans in the individual and small group markets.

In § 156.130(a), we codify the Affordable Care Act's annual limitation on cost sharing for 2014 and in subsequent years. Section 1302(c)(1)(A) of the Affordable Care Act identifies the limit on total enrollee cost-sharing that can be incurred. The annual limitation on cost sharing ensures that health plans pay for significant health expenses associated with EHB and the risk of medical debt or bankruptcy for individuals insured by such plans is limited. Once the limitation on cost sharing is reached for the year, the enrollee is not responsible for additional cost sharing for EHBs for the remainder of the plan year.

Section 156.130(a)(1) ties the annual limitation on cost sharing for plan years beginning on or after January 1, 2014, to the enrollee out-of-pocket limit for high-deductible health plans (HDHP), as calculated pursuant to section 223(c)(2)(A)(ii) of Internal Revenue Code of 1986 (the Code) based on section 1302(c)(1)(A) of the Affordable Care Act. Paragraph (a)(1)(i) addresses the limitation for self-only coverage and paragraph (a)(1)(ii) addresses the limitation for coverage other than self-only coverage; the practical effect for coverage other than self-only coverage is that the annual limitation will be double the limitation applicable to self-only coverage. For illustrative purposes only, for the year 2013 these amounts will be

\$6,250 in 2013 for self-only and \$12,500 for non-self only coverage.¹⁹ In § 156.130(a)(2)(i), we propose that the annual limitation on cost sharing is increased by the premium adjustment percentage, which is set by HHS as described in § 156.130(e), in years after 2014 for self-only coverage. In § 156.130(a)(2)(ii), we propose that the annual limitation on cost sharing in years after 2014 for non-self only coverage is double the annual limitation on cost sharing for self-only coverage for that year. These proposed rules basically codify the statute.

Sections 1302(c)(2)(A)(i) and 1302(c)(2)(A)(ii) of the Affordable Care Act define and § 156.130(b) codifies the annual limitation on deductibles for health plans offered in the small group market. This limitation on cost-sharing is imposed on QHPs by section 1301(a)(1)(B) of the Affordable Care Act and 45 CFR 156.200(b)(3). The limitation is also imposed on non-grandfathered coverage in the small group market by section 2707(b) of the PHS Act, which we propose here to implement in proposed 45 CFR 147.150(a). In § 156.130(b)(1)(i), we propose that the annual limitation on deductibles for the year 2014 are \$2,000 for self-only coverage and in § 156.160(b)(1)(ii), \$4,000 for non self-only coverage. In § 156.130(b)(2) we propose that in years beyond 2014, the annual deductible limits for self-only plans are increased by the premium adjustment percentage described in paragraph (e) based on section 1302(c)(2)(B) of the Affordable Care Act. In § 156.130(b)(2)(i), we specify this for self-only coverage and in § 156.130(b)(2)(ii), we specify this is doubled for family coverage or coverage of any type other than self-only.

Section 1302(c)(2)(C) of the Affordable Care Act directs that the limit on deductibles described in section 1302(c)(2)(A) for a health plan offered in the small group market be applied so as to not affect the actuarial value of any health plan. We interpret and implement this provision through our proposal at § 156.130(b)(3) by authorizing a health insurance issuer to make adjustments to its deductible to maintain the specified actuarial value for the applicable level of coverage required under proposed § 156.140 and annual limitation on cost sharing. In § 156.130(b)(3), we propose that a plan may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without doing so.

¹⁹ <http://www.irs.gov/pub/irs-drop/rp-12-26.pdf>.

We propose to use a “reasonableness” standard and request comment on what evidence or factors should be required from an issuer and considered in determining whether this standard is met with respect to health insurance coverage subject to 2707(b) of the PHS Act. While it may be possible to develop plan designs to meet all of these constraints, we believe it could be difficult to develop plans with reasonable coinsurance or equivalent cost sharing rates in the future, for example in bronze plans. An alternative would be to use the actuarial value calculator described in § 156.135 to determine a reasonable increase to the amounts described in paragraph (b) that can be used by all plans in the small group market. We solicit comment on this approach on whether a specific variation threshold should be identified, and if so, how any such threshold should be established.

Section 1302(c)(2)(A) of the Affordable Care Act provides that in certain circumstances, the deductible maximums described in § 156.130(b)(1) may be increased by the maximum amount of reimbursement “reasonably available” to an employee under a flexible spending arrangement (FSA) described in section 106(c)(2) of the Code. We considered permitting the maximum deductible to increase by the amount available to each employee under the FSA. Permitting such variability in the maximum deductible by employee would require different deductible plans to be available to different employees based on an FSA decision made during the open enrollment process. Because we interpret section 1302(c)(2)(A) of the Affordable Care Act as permitting but not requiring FSAs to be taken into account when determining the deductible maximum, we propose to standardize the maximum deductible for all health plans in the small group market at \$2,000 for self-only coverage and \$4,000 for non-self-only coverage, as described in § 156.130(b)(1) and potentially adjusted in § 156.130(b)(3), and not increase the deductible levels by the amount available under the FSA. However, we welcome comments on permitting such an adjustment, including permitting an employer to attest to the amount available to employees in an FSA as the basis for increasing the maximum permissible deductible for employees.

In § 156.130(c), we propose a special rule for network plans. Under our proposal, cost-sharing requirements for benefits from a provider outside of a plan’s network do not count towards the annual limitation on cost sharing, as

defined in paragraph (a) of this section, or the annual limitation on deductibles, as defined in paragraph (b) of this section. We consider an out-of-network provider to be a provider with whom the issuer does not have a contractual arrangement with respect to the applicable plan. For example, if an issuer offers a three-tiered network plan, with the third tier considered to be “out-of-network” (that is, providers without contractual relationships for providing services), only the cost sharing that an enrollee pays for benefits provided under the first and second tiers would count towards the annual limitation on cost sharing (and, if the plan is one offered in the small group market, the annual limitation on deductibles). Therefore, an enrollee who utilizes many services could reach the annual limitation on cost sharing, but still be required to pay cost sharing if the enrollee chooses to purchase services outside of the plan’s network that year. This policy aligns with the definition of the enrollee out-of-pocket limit for high deductible health plans, articulated in section 223(c)(2)(D) of the Code. We believe this policy would allow issuers greater flexibility to design innovative plan benefit structures. We note that nothing in this proposal explicitly prohibits an issuer from voluntarily establishing a maximum out-of-pocket limit applicable to out-of-network services, or a state from requiring that issuers do so. We welcome comment on this approach.

In § 156.130(d), we codify sections 1302(c)(1)(B) and 1302(c)(2)(B) of the Affordable Care Act by requiring that the annual limitation on cost sharing and the annual limitation on deductibles for a plan year beginning after calendar year 2014 only increase by multiples of \$50 and must be rounded to the next lowest multiple of \$50.

In paragraph (e), we codify section 1302(c)(4) of the Affordable Care Act, which specifies that the premium adjustment percentage is calculated as the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. This ensures that the annual limitation on cost sharing and the annual limitation on deductibles change with health insurance market premiums over time. HHS will publish the methodology and annual premium adjustment percentage in the annual

HHS notice of benefit and payment parameters.²⁰

In paragraph (f), we codify section 1302(c)(2)(D) of the Affordable Care Act, which states that the annual deductibles do not apply to preventive care described in § 147.130. In paragraph (g), under our authority in section 1302(b)(4)(B) of the Affordable Care Act prohibiting EHBs from discriminating against individuals based on age, disability, or expected length of life, and our general authority under section 1321(a)(1)(D) of the Affordable Care Act to establish appropriate requirements by regulation, we propose to require that cost-sharing requirements conform with the anti-discrimination provisions of § 156.125.

Paragraph (h) would implement the requirements in section 1302(b)(4)(E) of the Affordable Care Act that (1) emergency department services will be provided out-of-network²¹ without imposing any requirement under the plan for prior authorization of services, or any limitation on coverage for the provision of services, that is more restrictive than the requirements or limitations that apply to emergency department services received from network providers, and (2) cost sharing in the form of a copayment or coinsurance for emergency department services amount for an out-of-network provider is the same as would apply to an in-network provider. Because we have already promulgated regulations at § 147.138(b)(3) implementing identical statutory language in section 2719A(b)(1)(C)(ii)(II) of the Public Health Service Act regarding limitations on cost-sharing in the emergency room context, we are proposing to require in paragraph (h) that an issuer comply with the cost-sharing requirements at 45 CFR 147.138(b)(3). This treatment of out-of-network emergency services extends the in-network treatment of cost-sharing payments and limitations to out-of-network emergency services as a part of the annual limit on cost sharing defined in paragraph (a).

h. AV Calculation for Determining Level of Coverage (§ 156.135)

As we stated previously in connection with § 156.20, AV is a measure of the percentage of expected health care costs a health plan will cover for a standard

²⁰The annual HHS notice of benefit and payment parameters will first be published this year, as discussed in the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, final rule (77 FR 17220 (March 23, 2012)).

²¹For consistency, we are using the term “out-of-network” here to refer to services where the “provider of services does not have a contractual relationship with the plan,” as this phrase is used in section 1302(b)(4)(E).

population and can be considered a general summary measure of health plan generosity. The Affordable Care Act directs issuers offering non-grandfathered health insurance coverage in the individual and small group markets to ensure that plans meet a level of coverage specified in section 1302(a)(3) of the Affordable Care Act and defined in § 156.140(b). Under the statute, each level of coverage corresponds to an AV calculated based on the cost-sharing features of the plan as described above. In this section, we propose an approach for issuer calculation of AV as discussed in the AV/CSR Bulletin.²² In paragraph (a), we propose that an issuer would use the AV calculator developed by HHS to determine its level of coverage as proposed in § 156.140(b), subject to the exception in paragraph (b).

The AV calculator, as proposed here, has been developed using a set of claims data weighted to reflect the standard population projected to enroll in the individual and small group markets for the identified year of enrollment. Plans would input information on cost-sharing parameters. A methodology document including both the logic behind the calculator and a description of the development of the standard population, represented in the calculator as tables of aggregated data called continuance tables, is available and proposed at <http://cciio.cms.gov/resources/regulations/index.html#pm> to promote transparency. The document is part of the proposal for the use of the AV calculator in determining actuarial value of an applicable plan.

We solicit comment on the methodology for the development of the AV calculator and the continuance tables, which were developed based on the standard population. The consistent methodology in AV calculation ensures a consistent set of assumptions and methods in AV calculation for all health plans using the calculator, resulting in comparability for consumers since plans with the same cost-sharing design would have the same AV. Because empirically only a small percentage of total costs come from out-of-network utilization, the difference in a plan's AV resulting from the inclusion of out-of-network utilization in the AV calculation is small. Therefore, the proposal for determining AV and, thus, the calculator only considers in-network utilization. Comments from the American Academy of Actuaries to the AV Bulletin confirmed that, for the majority of plans, estimations only

including in-network cost sharing are appropriate even if some plans offer in-network services only, while other plans offer out-of-network services with higher cost-sharing, because in general, out-of-network costs are a very small percentage of total medical spending. The calculator and accompanying continuance tables are available at <http://cciio.cms.gov/resources/regulations/index.html#pm> and are subject to comment.

Under this proposal, the AV calculator will be available for both formal and informal calculations and could be used as a tool to assist in the design of health plans. The calculator will allow health plan issuers to devise a compliant plan without the burden of making the assumptions needed or paying for the analysis for an AV calculation. Thus, the calculator would reduce issuer burden in calculating AV. We solicit comment on this proposal to direct the use of the AV calculator and on the parameters described here for development of the AV calculator.

Consistent with section 1302(d)(2)(A) of the Affordable Care Act, that AV be calculated based on the provision of the EHB to a standard population, we propose that the AV calculator will use one or more sets of national claims data reflecting plans of various levels of generosity as the underlying standard population. We considered distributing a standard set of de-identified individual-level claims data to issuers as the standard population and allowing them to estimate the AV of their plans by comparing that standard set of claims against their plan designs. However, we are not aware at this time of a sufficiently robust person-level data set that could be made publicly available. As another alternative, we considered distributing only the continuance tables, representing the standard population and its utilization, to issuers to perform AV calculations. Under this method, the set of assumptions would be more uniform, but there would still be inconsistency and variation among issuers depending on the specific calculation method and logic used by each issuer. Comments on the AV/CSR Bulletin were generally supportive of the approach we propose here to develop a publicly available and transparent AV calculator based on a standard population represented through continuance tables.

In paragraph (b), we propose options for an issuer whose plan designs do not permit the calculator to provide an accurate summary of plan generosity. Although HHS anticipates that the vast majority of plans will be able to use the calculator in 2014 and beyond, no

uniform calculator can accommodate the entire potential universe of plan designs. Therefore, there may be a small subset of plans whose design would not be compatible with the calculator. We intend to interpret this standard as dependent on whether the calculator takes into account or accommodates all material aspects of a plan's cost sharing structure. For example, we expect that the calculator will not be able to accommodate plan designs with multiple coinsurance rates as different levels of out-of-pocket spending are met or a multi-tier network with substantial amounts of utilization expected in tiers other than the lowest-priced tier. As proposed in paragraph (b)(1), these plans would need to submit to the appropriate entity (the state, HHS, the Exchange, or OPM) documentation in the form of actuarial certification that they have complied with one of the methods described below.

Paragraph (b)(2) proposes two options to accommodate plans with benefit designs that cannot be accommodated by the AV calculator. In paragraph (b)(2)(i), we propose that a health plan issuer be permitted to decide how to adjust the plan benefit design (for calculation purposes only) to fit the parameters of the calculator and then, pursuant to paragraph (b)(2)(ii), have an actuary who is a member of the American Academy of Actuaries certify that the methodology is in accordance with generally accepted actuarial principles and methodologies. In paragraph (b)(3), we propose a second option, that the plan may use the calculator for the plan design provisions that correspond to the parameters of the calculator and then have a member of the American Academy of Actuaries calculate appropriate adjustments to the AV as determined by the AV calculator for plan design features that deviate substantially, in accordance with generally accepted actuarial principles and methodologies. We propose in paragraph (b)(4) that, to align with the AV calculator and the rules proposed here for how AV is determined, plans using one of these methods would exclude out-of-network costs when using additional calculation methods. We also note, however, that a multi-tiered plan should consider all network tiers in its AV calculation and exclude only costs that are truly out-of-network (providers with which the plan has no contractual relationship).

In paragraph (c), we propose a standard for the treatment of small group market HDHPs offered with a health savings account (HSA) or a health plan in the small group market integrated with a health reimbursement

²² Available at <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>.

arrangement (HRA), so that HDHP and HSAs/HRAs are integrated. Recognizing that simply calculating the AV of the HDHP based on the insurance plan alone could understate the value of coverage if the values of the employer contribution to such accounts are not included, and that employer-provided HSAs and HRAs are generally the equivalent of first dollar coverage for any cost-sharing requirements encountered by the enrollee, in paragraph (c)(1), we propose 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.

Section 1302(d)(2)(B) of the Affordable Care Act directs the Secretary to issue regulations under which employer contributions to an HSA (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer. HHS is interpreting the statute to allow for a similar treatment of HRAs because amounts newly made available under an HRA integrated with a small group market plan have a similar impact on AV calculation as employer contributions to an HSA when adjusted as described below in the discussion of paragraphs (c)(2)(i) and (c)(2)(ii). In paragraph (c)(2), we propose that these contributions be applied to the plan design to account for the fact that HSA and HRA contributions are the equivalent of first dollar coverage for any cost-sharing requirements encountered by the enrollee and similar to other employer cost-sharing contributions to plan design.

In paragraphs (c)(2)(i) and (c)(2)(ii), we propose that the AV calculator would include any current year HSA contributions or amounts newly made available under an HRA for the current year as an input into the calculator that can be used to determine the AV of an employer health benefit plan. We note that employee HSA contributions will not count towards AV, nor do these provisions apply to the coverage offered by issuers in the individual market because HSAs in the individual market are funded directly by the enrollee.

Paragraph (d) proposes that in years 2015 and after, a state-specific data set may be used as the standard population

(i.e. in place of the HHS-issued continuance tables) for AV calculations if approved by HHS. Issuers in such a state would still use the AV calculator logic, but the underlying data used for generating the AV would be specific to the state. Paragraphs (d)(1) through (5) propose criteria for acceptable state claims data and their use. The proposed criteria are based on our review of a July, 2011 American Academy of Actuaries issue brief.²³ Paragraph (d)(1) proposes that the data support the calculation of AVs for the full range of health plans available in the market, meaning that the structure and definitions for the data set must be standardized and clearly documented. Paragraph (d)(2) proposes that the underlying population must be derived from the non-elderly population likely to be covered by private plans in the 2014 market and beyond. For example, the underlying population cannot be based primarily on Medicaid or Medicare enrollees. This criterion is also intended to ensure that the data set represents members in the then current small group and individual markets for the state. Paragraph (d)(3) proposes that the data set must be large enough so that (i) demographic patterns and spending patterns are stable over time to accommodate periodic updates and (ii) a substantial majority of the state's insured population is included, subject to the requirement in paragraph (2) to cover the expected insured population in 2014. Paragraph (d)(4) proposes that, if a state intends to reflect geographic differences within the state, the data set must be sufficiently large and geographically diverse for area-specific calculations. Paragraph (d)(5) proposes that the data set must capture a wide range of health care services typically offered, including those that fall within EHB and are at the time of submission offered in a typical employer plan. For example the data set must include claims for maternity, prescription drugs, and mental health benefits. Comments on the AV/CSR Bulletin²⁴ generally supported the proposal to allow states the flexibility to provide their own data sets. Some groups commented that the state data would need to be at least as robust as the national data set. HHS believes that the parameters outlined above, and adopted from the American Academy of Actuaries' recommendations, will ensure that state specific data are sufficiently robust. We solicit comment on this proposal and

²³ Available at http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf.

²⁴ <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>.

our adoption of criteria identified by the American Academy of Actuaries.

In paragraph (e), HHS proposes that the default standard population provided by HHS, which is described in paragraph (f) and represented in the continuance tables incorporated into this regulatory proposal by reference, would be used unless the state submits its own standard population consistent with paragraphs (d) and (e). In paragraph (e), HHS proposes that the state data set be submitted in a format that can support the AV calculator described in paragraph (a). Because HHS will use continuance tables to support the development of the AV calculator, we anticipate that states will also submit any state-specific data sets in the form of continuance tables. HHS intends to provide a template and instructions for these submissions.

Several comments on the AV/CSR Bulletin requested additional guidance on the process and timeline for state submission of data. We remain open to comments on the use of state data for 2014, but given timing constraints, we propose that the option for states to submit a state-specific standard population will begin for plan years starting in 2015. We expect that submissions will be due in the second quarter of the year prior to the benefit year.

Paragraph (f) proposes that HHS will develop the standard population to be used to calculate AV in accordance with section 1302(d)(2)(A) of the Affordable Care Act, which requires that AV be calculated using a standard population. This standard population will be used for AV calculation under § 156.135. Comments on the AV/CSR Bulletin were generally supportive of the proposal to use a standard data set developed by HHS, with the option of state flexibility to provide a state-specific data set for AV calculations. We solicit comment on whether the AV calculator should allow for this variation between states. We also solicit comment on whether we should consider including up to three regional adjustments for geographic price differences as described in the AV/CSR Bulletin.

i. Levels of Coverage (§ 156.140)

This section describes standards for meeting the Affordable Care Act provisions that issuers offering QHPs or non-grandfathered health plans in the individual and small group markets offer plans that meet distinct levels of coverage; we note that an applicable issuer may offer a catastrophic plan, as described in section 1302(e) of the Affordable Care Act, in lieu of a health plan that meets one of these levels of

coverage. Section 1302(d)(2) of the Affordable Care Act directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage.

Paragraph (a) proposes the general requirement that the AV of a plan must be calculated according to § 156.135, within de minimis variation, in order to determine a plan's level of coverage.

Paragraph (b) proposes to codify section 1302(d)(1) of the Affordable Care Act, which requires that a bronze plan has an AV of 60 percent; a silver plan, 70 percent; a gold plan, 80 percent; and a platinum plan, 90 percent.

Paragraph (c) proposes standards for de minimis variation. Section 1302(d)(3) of the Affordable Care Act authorizes the Secretary to determine a reasonable de minimis variation in the AVs used to determine levels of coverage. In paragraph (c), we propose a de minimis variation of +/- 2 percentage points for all non-grandfathered plans. For example, a silver plan could have an AV between 68 and 72 percent. We believe that a de minimis amount of +/- 2 percentage points strikes the right balance between ensuring comparability of plans within each metal level and allowing plans the flexibility to use convenient cost-sharing metrics. Comments on this proposal in the AV/CSR Bulletin were generally supportive of this approach.

j. Determination of Minimum Value (§ 156.145)

Section 1302(d)(2)(C) of the Affordable Care Act sets forth the rules for calculating the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage. Section 36B(c)(2)(C)(ii) of the Code provides that an employer-sponsored plan provides minimum value (MV) if this percentage is no less than 60 percent. For the purpose of determining that a given plan provides MV, we propose in paragraph (a) that the percentage of the total allowed cost of benefits will be determined using one of the main methodologies as described in Treasury Notice 2012-31, released on May 14, 2012 ("MV Notice"). We also propose, in paragraph (c), that MV for employer-sponsored self-insured group health plans and insured large group health plans will be determined using a standard population that is based upon large self-insured group health plans. We also propose that employer contributions to an HSA and amounts newly made available under an HRA will be taken into account in determining MV in accordance with the principles applied in taking such

amounts into account in determining AV.

In applying this approach to determining MV, in paragraph (a)(1), we propose that employer-sponsored self-insured and insured large group plans will be able to use the MV calculator, which will be made available by HHS and the Internal Revenue Service. Under this proposal, the MV calculator will be similar in design to the AV calculator but based on continuance tables and a standard population reflecting claims data of typical self-insured employer plans. This will be a better reflection of the typical employer plan that will use the MV calculator, resulting in a similar or higher actuarial value than the AV calculator for the same benefit designs. This approach would permit an employer-sponsored plan to enter information about the plan's cost sharing to determine whether the plan provides MV.

As an alternative to using the MV calculator, we propose in paragraph (a)(2) that an employer-sponsored plan would be able to use an array of design-based safe harbors published by HHS and the Internal Revenue Service in the form of checklists to determine whether the plan provides MV. Each safe harbor checklist would describe the cost sharing attributes of a plan that apply to the following four core categories of benefits and services which comprise the vast majority of group health plan spending as described in the MV Notice: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services.

Finally, if an employer-sponsored plan contains non-standard features that are not suitable for the use of the calculator and do not fit the safe harbor checklists, we propose in paragraph (a)(3) to permit MV to be determined through certification by an actuary without the use of the MV calculator. The actuary would make this determination based on the plan's benefits and coverage data and the standard population, utilization, and pricing tables available for purposes of the valuation of employer-sponsored plans. This final option would be available only when one of the other methodologies is not applicable to the employer-sponsored plan. We propose that the determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies. We intend to issue applicable guidance concerning the actuarial analysis.

In the event that a plan uses the MV calculator and offers an EHB outside of the parameters of the MV calculator, we propose in paragraph (b)(1) that an actuary who is a member of the American Academy of Actuaries will be permitted to determine the value of that benefit and add it to the result derived from the MV calculator in accordance with the generally accepted actuarial principles and methodologies. This aims to consider the value of benefits that are among the EHB options, but not necessarily in a state benchmark because there is no EHB standard for employer-sponsored self-insured group health plans or insured large group health plans. There is no requirement that employer-sponsored self-insured and insured large group health plans offer all categories of EHB or conform to any of the EHB benchmarks. For clarity, alignment, and administrative ease, we propose in paragraph (b)(2), for purposes of determining that a group health plan provides MV, that such plans will be permitted to take into account all benefits provided by the plan that are included in any of the EHB benchmarks.

We also propose, in paragraph (c), that MV determinations under § 156.145(a) will be based on a standard population based on data from self-insured group health plans.

k. Application to Stand-alone Dental Plans inside the Exchange (§ 156.150)

Section 1302 of the Affordable Care Act outlines the standards for health plans to cover the ten categories of the EHB. Section 1311(d)(2)(B)(ii) of the Affordable Care Act, as codified in § 155.1065 of this subchapter, allows the pediatric dental component of the EHB to be offered through a stand-alone dental plan in an Exchange. If stand-alone dental plans are available in an Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits QHPs offered in that Exchange to exclude coverage of the pediatric dental component of the EHB. This is the only exception to EHB coverage permitted under section 1302. Section 1311 also outlines how cost-sharing limits and AV would apply to such stand-alone dental plans.

In paragraph (a), we propose that stand-alone dental plans would have a separate annual limitation on cost sharing from QHPs covering the remaining EHBs. While the annual limitation on cost-sharing for a QHP must be consistent with § 156.130, the annual limitation on cost sharing for a stand-alone dental plan would be considered separately. We propose that the plan must demonstrate the annual

limitation on cost sharing for the stand-alone dental plan is reasonable for coverage of the pediatric dental EHB. We request comment on this proposal and what parameters should be considered a “reasonable” annual limitation on cost sharing. We note that the annual limitation on cost sharing would be applicable to in-network services only, consistent with § 156.130(c).

We considered applying the full annual limitation on cost sharing described in section 1302(c) of the Affordable Care Act separately to stand-alone dental plans. However, if a person purchased pediatric dental benefits through a stand-alone plan, it would effectively double the potential out-of-pocket costs, putting individuals with similar coverage, but purchasing pediatric dental through a stand-alone plan, at much greater financial risk.

Another alternative would be to exclude the pediatric dental benefit entirely from the annual limitation on cost sharing, whether it is offered through a health plan or through a stand-alone dental plan. However, we were concerned that not applying any annual limitation on cost sharing to stand-alone dental plans would treat such benefits differently than plans offering an embedded pediatric dental benefit, which could create a price advantage over medical plans.

We also considered requiring that the combination of the annual limitations on cost-sharing in the QHP and the stand-alone dental plan must not exceed the limitations identified in § 156.130, regardless of whether the person received coverage through a health plan that covers all of the 10 EHB categories including dental, or received coverage through a combination of a QHP and a stand-alone dental policy. However, this approach would entail a high level of coordination between an Exchange, QHP issuers, and issuers of stand-alone dental plans to track an enrollee’s cost sharing and notify the issuers if the limit was reached, which we are concerned may be difficult to administer.

We request comment generally on whether this approach to applying the annual limitations on cost-sharing standard is appropriate for stand-alone dental plans.

In paragraph (b), we propose actuarial value standards for stand-alone dental plans. The calculator developed by HHS under § 156.135 would be inappropriate for stand-alone dental plans because the standard population that underlies the HHS-developed calculator cannot be reasonably adapted to reflect a pediatric-only population that utilizes

dental services. Accordingly, in paragraph (b)(1), we propose that stand-alone dental plans may not use the HHS-developed AV calculator. Instead, given the unique and narrow focus of the stand-alone dental plan market, we propose in paragraph (b)(2) that any stand-alone dental plan certified to meet an 75 percent AV, with a de minimis range of +/- 2 percentage points, be considered a “low” plan and anything with an AV of 85 percent, with a de minimis range of +/- 2 percentage points, be considered a “high” plan. We request comment on whether a de minimis variation of +/- 2 percentage points is feasible for stand-alone dental plans. The “high/low” actuarial value standard would apply to the pediatric dental EHB only in a stand-alone dental plan. We note that when the pediatric dental EHB is included in a health plan, the AV calculator would apply to the pediatric dental EHB. In order to meet this standard we propose in paragraph (b)(3) that the issuer of a stand-alone plan demonstrate that the plan meets the “high” or “low” level of coverage as certified by a member of the American Academy of Actuaries using generally accepted actuarial principles. This proposal would provide a means of comparison for consumers as well as providing a comparable method of fulfilling the offering requirements laid out in § 156.200(c)(1). We request comment on this proposal and whether the actuarial value standards for a “high” and “low” plan are appropriate.

As an alternative, we considered requiring that a stand-alone dental plan meet at least a silver or gold level of coverage as certified by a member of the American Academy of Actuaries using generally accepted actuarial principles. However, some commenters noted that because pediatric dental coverage is comprised largely of preventive services with 100 percent cost-sharing covered by the plan, in order to meet a 70 percent AV, issuers of stand-alone dental plans would need to add a deductible that is not currently included in plans. In contrast, our proposal would be more in line with current industry practices and would result in fewer out-of-pocket costs for consumers.

3. Subpart C—Accreditation

Accreditation of QHP Issuers (§ 156.275)

Recognition of Accrediting Entity by HHS (§ 156.275(c)(1) and § 156.275(c)(4))

This proposed rule would amend the current (“phase one”) recognition process and provide additional accrediting entities the opportunity to apply and demonstrate how they meet

the conditions for recognition articulated in section 1311(c)(1)(D) of the Affordable Care Act and 45 CFR 156.275(c)(2) through (c)(5).²⁵ HHS intends, through future rulemaking, to establish a phase two recognition process which may establish additional criteria for recognized accrediting entities.

HHS’s initial survey of the market showed that two entities, NCQA and URAC, met the statutory requirements for accreditation. During the public comment period for 45 CFR 156.275, additional accrediting entities indicated that they may soon meet the accreditation conditions specified in 45 CFR 156.275 (c)(2) and (c)(3). HHS believes that opening up the phase one recognition process to provide other entities an opportunity to apply would provide expanded choices regarding QHP accreditation for Exchanges, states and issuers.

Therefore, HHS proposes to amend § 156.275(c)(1) to provide an application and review process for phase one recognition of accrediting entities. Under this proposal, accrediting entities could apply and demonstrate how they meet the requirements for recognition as established in 45 CFR 156.275 (c)(2) and (c)(3). Such applications must include the documentation described in 45 CFR 156.275(c)(4), including current accreditation standards and requirements, processes, and measure specifications for performance measures, and a document that illustrates how (via a crosswalk) the accrediting entity meets the standards established in § 156.275(c)(2) and (c)(3). This proposal would require HHS, within 60 days of receiving the complete application, to publish a notice in the **Federal Register** identifying the accrediting entity making the request for phase one recognition, summarizing HHS’s analysis of whether the applicant meets the criteria for recognition, and providing no less than a 30-day public comment period on this applicant accrediting entity. HHS will compare the applicant accrediting entity’s standards and processes to the requirements for recognition established in 45 CFR 156.275(c)(2) and (3). This assessment will be the same as that underlying the recognition of NCQA and URAC. After the close of the comment period, HHS will notify the public in the **Federal Register** of the names of the accrediting entities

²⁵ Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans (CMS–9965–F), 77 FR 42,658 (July 20, 2012).

recognized and not recognized to provide accreditation of QHPs for the purposes of QHP certification. If an accrediting entity is not recognized, then it may re-apply for recognition following the same application procedure as proposed in § 156.275(c)(1).

HHS is also amending § 156.275(c)(4)(i) to delete the timeframe of submitting the documentation within 60 days of publication of this final rule. Under the amended application and review process proposed in § 156.275(c)(1), accrediting entities must provide the documentation described in § 156.275(c)(4)(i) with their application for review.

In a **Federal Register** notice being published concurrently with this proposed rule, we are notifying the public that NCQA and URAC are recognized as accrediting entities for the purposes of QHP certification consistent with the final rule published on July 20, 2012. NCQA and URAC do not need to reapply under this proposal but remain subject to the requirements of 45 CFR 156.275(c), including (c)(4)(ii), which requires recognized accrediting entities to provide to HHS any proposed changes or updates to the accreditation standards and requirements, processes, and measure specifications for performance measures with 60 days' notice prior to public notification. This proposed amendment of § 156.275(c) only renumbers the applicable portion of the regulation recognizing NCQA and URAC. As discussed in the preamble to the final rule published on July 20, 2012, the recognition of accrediting entities in phase one is effective until it is rescinded or this interim phase one process is replaced by the phase two process.

III. Collection of Information

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before an information collection request is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.

- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Below is a summary of the proposed information collection requirements outlined in this regulation. Throughout this section we assume that each data collection will occur on an annual basis unless otherwise noted. We used the Bureau of Labor Statistics (BLS) Web site to identify salary data, unless otherwise indicated. Fringe benefit estimates were taken from the BLS March 2011 Employer Costs for Employee Compensation report. These compensation estimates were selected to align with the burden estimates for the data collections described in the "Establishment of Exchanges and Qualified Health Plans Final Rule" (77 FR 18310 (March 27, 2012)). For purposes of presenting an estimate of paperwork burden, we reflect the operation of an Exchange in fifty states and the District of Columbia. Similarly, we estimate the burden for issuers participating in all 51 Exchanges. Therefore, these estimates should be considered an upper bound of burden estimates. These estimates may be adjusted in future Paperwork Reduction Act (PRA) packages. We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Additional Required Benefits (§ 155.170(c))

In § 155.170(c), we direct issuers to quantify and report to the Exchange the cost attributable to required benefits in addition to EHB. This is a third-party disclosure requirement. Issuers will use a uniform rate template in a revision to the Rate Increase Disclosure and Review Reporting Requirements PRA package (CMS-10379) (Rate Review PRA package) to report this information. The burden associated with meeting this data collection is included in the Rate Review PRA package. A **Federal Register** notice seeking comments on this PRA package is being published concurrently with this proposed rule.

As noted in the Rate Review PRA package, we estimate that a total of 2,010 issuers in the individual market and 1,050 issuers in the small group market will offer products and that each issuer will have an average of 2.5 submissions per year. We anticipate that it will take an actuary a total of 11 hours to complete the uniform rate template, at \$225 per hour for an actuary. The total annual burden is estimated to be \$18,933,750. Of this total amount, only a fraction can be attributable to the

portion of the uniform rate template that pertains to benefits in addition to EHB. We estimate that of the total 11 hours it will take an actuary to complete the uniform rate template, it will take an actuary 1 hour to complete the portion pertaining to benefits in addition to EHB. Therefore, we estimate the burden attributable to the collection of information regarding benefits in addition to EHB to be \$1,721,250. Given the policies included in this proposed rule regarding state required benefits, we seek comment on this estimated time for additional benefits.

B. ICRs Regarding State Selection of Benchmark (§ 156.100) and EHB Benchmark Plan Standards (§ 156.110)

In § 156.100, we propose that a state may select a base-benchmark plan to serve as a reference plan to define EHB in that state. We also propose that if a state does not select a benchmark plan, its base-benchmark will be the largest plan by enrollment in the largest product in the state's small group market. In § 156.110, we propose that a state-selected or default benchmark plan must offer coverage in each EHB category, as required by the Affordable Care Act. We propose that if a base-benchmark plan does not offer coverage in a category, it must be supplemented to include those missing benefit categories.

We do not believe that this is a change to the information collection associated with state selection and submission of a benchmark plan and associated benefits and the data collection to establish default benchmark plans, including any required supplementing, which is already captured in the collection approved under OMB Control Number 0938-1174.

C. ICRs Regarding AV Calculation for Determining Level of Coverage (§ 156.135)

In § 156.135(b), we propose to create an exception to using the AV calculator for issuers with health plans that are not designed in a way that is compatible with the AV calculator. To take advantage of this exception, issuers must submit an actuarial certification on their alternative method to the state, HHS, the Exchange, or OPM. This is a third-party disclosure requirement when the issuers submit to the state or the Exchange, and this is a reporting requirement when the issuers submit to HHS, OPM, or a Federally-facilitated Exchange. We account for this collection in the Initial Plan Data Collection to Support Qualified Health Plan Certification and Other Financial Management and Exchange Operations

PRA package (CMS–10433) (QHP Certification PRA package). A **Federal Register** notice regarding this PRA package is being published concurrently with this proposed rule.

In the QHP Certification PRA package, we estimate that 1,200 issuers will each offer 15 potential QHPs, for a total of 18,000 potential QHPs, and that the per-issuer burden will be 175 hours. We estimate the cost per issuer in the first year of operations to be \$13,475, which represents an aggregation of several staff, including actuarial staff. This PRA package includes data collections for QHP certification, risk adjustment, and reinsurance. We believe that only 5 percent of issuers will be unable to use the AV calculator, thus use the process proposed in § 156.135(b) and that it will take each issuer 8 of the total 175 hours to provide the requested information. We further assume that the 8 hours of work would be performed by an actuary, at \$225 per hour. Therefore, we estimate the total cost attributable to § 156.135(b) to be \$1,800 per QHP and \$1,620,000 in total.

In § 156.135(d), we propose that beginning in 2015, a state may submit a state-specific standard population, to be used for AV calculation, so long as the criteria described in § 156.135(d)(1) through (6) are met. This will require the state to submit to HHS summary evidence that the requirements described in the proposed rule are met and the dataset in a format that will support the use of the AV calculator. We expect that for each state choosing this option, the data submission will require 15 hours from a database administrator at \$47.70 an hour, 4 hours of actuarial work at \$56.89 an hour, and 1 hour of management review at \$75.15 an hour. Therefore, the total burden associated with the reporting requirement for each state choosing this option will be \$1,018. We assume that states opting to develop a state-specific standard population will provide new data every three to five years.

D. ICRs Regarding Stand-Alone Dental Plans Inside the Exchange (§ 156.150(a))

In § 156.150(a), we propose that stand-alone dental plans covering the pediatric dental EHB under § 155.1065 must demonstrate to the Exchange that they have a reasonable annual limitation on cost sharing. This is a third-party disclosure requirement.

We account for this collection in the QHP Certification PRA package, where we estimate that 40 issuers will each offer a stand-alone dental plan, and that the burden for certification will be 6 hours per issuer, at a total hourly billing rate of \$77, for a total cost of \$462 per

issuer. We estimate that of those 8 hours, 1 will be attributable to demonstrating that the annual limitation on cost sharing is reasonable, at a cost of \$77 per plan. Therefore, across 40 plans, we estimate the total annual cost to be \$3,080.

E. ICRs Regarding Accreditation (§ 156.275)

In § 156.275, HHS proposes an amendment to the phase one process by which accrediting entities can submit an application to be recognized by HHS for purposes of accrediting QHPs. HHS previously sought OMB approval for recognition of two specific entities under § 156.275(c)(1); this was approved under OMB Control Number 0938–1176. Under this proposed rule, this same process will be open to additional applicants; therefore, we propose to revise our estimate of the number of applicants to four. We will revise the information collection request approved under OMB Control Number 0938–1176 to account for the adjustment in the number of respondents and the corresponding adjustment to the burden. If you comment on these information collection requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or
2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, [insert filecode], Fax: (202) 395–6974; or Email: OIRA_submission@omb.eop.gov.

IV. Regulatory Impact Analysis

HHS has examined the impacts of this proposed regulation under Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866—emphasizing the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (\$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the Office of Management and Budget (OMB). Section 3(f) of Executive Order 12866 defines a “significant regulatory action.” In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget as an economically significant regulatory action.

A. Summary

As stated earlier in this preamble, this proposed regulation would implement the requirements related to EHB and AV levels of coverage, and establish the timeline according to which QHP issuers participating in FFEs must be accredited. We note that the Exchange regulation (45 CFR 156.200) established that QHPs will cover essential health benefits, as defined by the Secretary, and that QHPs be accredited on the basis of local performance. The cost to health plans of obtaining QHP certification and participating in Exchanges are already accounted for in the regulatory impact analysis that accompanies that regulation.²⁶ Therefore, this analysis describes the incremental costs, benefits, and transfers associated with provisions in this proposed rule, for example that health plans cover the essential health benefits as specifically defined herein, and that health plans use the HHS-developed AV calculator.

This proposed rule also contains details relating to the establishment of a timeline by which QHPs seeking certification by FFEs must be accredited. We do not believe that this results in incremental benefits, costs, or transfers.

HHS has proposed this regulation to implement the protections intended by the Congress in the most economically efficient manner possible. In accordance with OMB Circular A–4, HHS has quantified the benefits, costs and transfers where possible, and has also provided a qualitative discussion of some of the benefits, costs and transfers that may stem from this proposed regulation.

²⁶ “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS–9989–FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS–9975–F): Regulatory Impact Analysis.” Centers for Medicare & Medicaid Services. Available at: <http://ccio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf>.

B. Overview of Key Provisions in the Proposed Rule

As described earlier in this proposed rule, the Affordable Care Act directs the Secretary of the Department of Health and Human Services (the Secretary) to define EHB such that EHB includes at least and reflects an appropriate balance among 10 benefit categories, and is equal in scope to benefits offered by a typical employer plan. Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, including multi-state plans, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs, if applicable, must cover EHB beginning in 2014. This proposed rule establishes how the Secretary will define EHB based on a state-specific benchmark plan and lays out standards for the EHB-benchmark plan and for issuers that cover EHB.

In addition, the Affordable Care Act directs issuers offering non-grandfathered health in the individual and small group markets to ensure that any offered plan meets specific AVs. The proposed rule outlines a process for computing plan AV using an HHS-developed AV calculator, as well as standards and flexibility for issuers in meeting the metal tiers.

C. Need for Regulatory Action

This rule proposes standards related to EHB and AV consistent with the Affordable Care Act. HHS believes that the provisions that are included in this proposed rule are necessary to fulfill the Secretary's obligations under sections 1302 and 1311 of the Affordable Care Act. Establishing specific approaches for defining EHB and calculating AV will bring needed clarity for states, issuers, and other stakeholders. Absent the provisions outlined in this proposed rule, states, issuers, and consumers would face significant uncertainty about

how coverage of EHB should be defined and evaluated. Similarly, failing to specify a method for calculating AV could result in significant inconsistency across states and issuers. Finally, establishing a clear timeline for potential QHPs to become accredited is essential to successful issuer participation in FFEs.

D. Summary of Impacts and Accounting Table

In accordance with OMB Circular A-4, Table IV.1 below depicts an accounting statement summarizing HHS's assessment of the benefits, costs, and transfers associated with this regulatory action.

HHS anticipates that the provisions of this proposed rule will assure consumers that they will have health insurance coverage for essential health benefits, and significantly increase consumers' ability to compare health plans, make an informed selection by promoting consistency across covered benefits and levels of coverage, and more efficiently purchase coverage. This proposed rule ensures that consumers can shop on the basis of issues that are important to them such as price, network physicians, and quality, and be confident that the plan they choose does not include unexpected coverage gaps, like hidden benefit exclusions. It also allows for some flexibility for plans to promote innovation in benefit design.

Insurance contracts are extremely complicated documents; therefore, many consumers may not understand the content of the contracts they purchase.²⁷ This complexity has two undesirable results. First, consumers may unknowingly purchase a product that does not meet their basic needs—the product may not cover benefits that the consumer needs to restore or maintain good health, or may result in more financial exposure than the

consumer anticipated. Second, the complexity reduces competitive pressure on insurers, and blunts insurer incentives to improve the quality and value of the products they offer. As a result of complexity and information gaps, some consumers cannot purchase health insurance efficiently. This inefficiency may reduce incentives for insurers to improve the value of their products.

The specific approach to defining EHB in this proposed rule realizes the benefits of simplicity and transparency by allowing each state to choose a benchmark from a set of plans that are typical of the benefits offered by employers in that state. The proposed rule allows that EHB in each state reflect the choices made by employers and employees in that state today, and minimizes disruption in existing coverage in the small group market. In addition, the proposed provisions addressing specific benefit categories, such as habilitative services and pediatric dental and vision services, will improve access to care for consumers who require these benefits.

The approach to defining AV in this proposed rule uses standard assumptions about utilization and prices, and, for most products, directs issuers to use an AV calculator created by the Department to compute AV. This approach will ensure that two plans with the same cost-sharing parameters (that is, deductibles, copayments, and coinsurance features) will have the same AVs. This approach is intended to lower consumer information costs and drive competition in the market by enabling consumers to easily compare the relative generosity of plans, knowing that the AV of each plan has been calculated in the same manner.

In accordance with Executive Order 12866, HHS believes that the benefits of this regulatory action justify the costs.

TABLE IV.1—ACCOUNTING TABLE

Category	Estimates	Units		
		Year dollar	Discount rate (percent)	Period covered
Benefits:				
Annualized Monetized (\$millions/year)	Not Estimated	2012	7	2012–2016
	Not Estimated	2012	3	2012–2016
Qualitative:	(1) Improved coverage in benefit categories less typically available. Expanded access to coverage of benefits, particularly in the individual market, including maternity and prescription drug coverage. (2) Alignment with current consumer and employer choices. Flexibility for states; limited market disruption; allowance for health plan innovation (e.g., substitution within benefit categories; de minimis variation for AV).			

²⁷ Consumers Union. (2012). "What's Behind the Door: Consumers' Difficulties Selecting Health

Plans." Available at: <http://www.consumersunion.org/pub/pdf/>

[Consumer%20Difficulties%20Selecting%20Health%20Plans%20Jan%202012.pdf](#).

TABLE IV.1—ACCOUNTING TABLE—Continued

Category	Estimates	Units		
		Year dollar	Discount rate (percent)	Period covered
	(3) Efficiency due to greater transparency. Increased transparency and consumer ability to compare coverage.			
Costs:				
Annualized Monetized (\$millions/year)	\$1.7*	2012	7	2012–2016
	\$1.5*	2012	3	2012–2016
Qualitative	(1) Administrative costs. Insurers will incur administrative costs associated with altering benefit packages to ensure compliance with the definition of EHB established in this proposed rule. Issuers may also incur minor administrative costs related to computing AV. (2) Costs due to higher service utilization. As consumers gain additional coverage for benefits that previously did not meet the standards outlined in this proposed rule (for example, pediatric dental or vision coverage), utilization, and thus costs, may increase. A portion of this increased utilization and costs will be economically inefficient, as insurance coverage creates a tendency to overuse health care. Further, there may be incremental costs to consumers associated with greater service utilization.			
Transfers:				
Federal Annualized Monetized (\$millions/year)	Not Estimated	2012	7	2012–2016
	Not Estimated	2012	3	2012–2016

* **Note:** Administrative costs include costs associated with Information Collection Requirements as described in section III of this proposed rule.

E. Methods and Limitations of Analysis

There are many provisions of the Affordable Care Act that are integral to the goal of expanding access to affordable insurance coverage, including the provisions of this proposed rule relating to EHB and AV. Because it is often difficult to isolate the effects associated with each particular provision of the Affordable Care Act, we discuss the evidence relating to the provisions of this proposed rule, as well as related provisions of the Affordable Care Act, in this regulatory impact analysis. We present quantitative evidence where it is possible and supplement with qualitative discussion.

F. Estimated Number of Affected Entities

As discussed elsewhere in the preamble, standards relating to EHB and AV will apply to all health insurance issuers offering non-grandfathered coverage in the individual and small group markets—both inside and outside of the Exchanges. The following sections summarize HHS’s estimates of the number of entities that will be affected by this proposed regulation.

a. Issuers

For purposes of the regulatory impact analysis, we have estimated the total number of health insurance issuers that will be affected by this proposed

regulation at the company level because this is the level at which issuers currently submit their annual financial reports to the National Association of Insurance Commissioners (NAIC). Table IV.2 shows the estimated distribution of issuers offering comprehensive major medical coverage in the individual and small group markets based on data submitted on the National Association of Insurance Commissioners’ 2011 Supplemental Health Care Exhibit (SHCE).²⁸ Additionally, because many issuers are licensed in more than one state, we have also included data by “licensed entity” (company/state combination) for each market.

TABLE IV.2—ESTIMATED NUMBER OF ISSUERS AND LICENSED ENTITIES AFFECTED BY THE EHB AND AV REQUIREMENTS BY MARKET, 2011

Description	Issuers ⁽¹⁾ offering comprehensive major medical coverage		Licensed entities ⁽²⁾ offering comprehensive major medical coverage	
	Number	Percent of total	Number	Percent of total
Total Issuers Offering Comprehensive Major Medical Coverage ⁽³⁾	446	100.0	2,107	100.0
By Market: ⁽⁴⁾				
Individual Market	355	79.6	1,663	78.9
Small Group Market ⁽⁵⁾	366	82.1	1,039	49.3
Large Group Market	375	84.1	922	43.8

²⁸ The most complete source of data on the number of entities offering fully insured, private comprehensive major medical coverage in the individual and group markets is the National Association of Insurance Commissioners (NAIC) Annual Financial Statements and Policy Experience Exhibits database. These data contain information

that issuers submit to the NAIC through State insurance regulators on four different financial exhibits (the Health, Life, Property & Casualty, and Fraternal “Blanks”). The 2011 SHCE captures data on individual, small group and large group comprehensive major medical coverage at the State level in a consistent manner across all Blanks,

providing more extensive information about this market than was previously available. We note that issuers electing not to offer non-grandfathered individual or small group market policies would not be affected by the proposed rule.

TABLE IV.2—ESTIMATED NUMBER OF ISSUERS AND LICENSED ENTITIES AFFECTED BY THE EHB AND AV REQUIREMENTS BY MARKET, 2011—Continued

Description	Issuers ⁽¹⁾ offering comprehensive major medical coverage		Licensed entities ⁽²⁾ offering comprehensive major medical coverage	
	Number	Percent of total	Number	Percent of total
Individual and/or Small Group Markets ⁽⁶⁾	427	95.7	1,993	94.6
Individual Market Only	82	18.4	904	42.9
Small Group Market Only	39	8.7	117	5.6
Individual & Small Group Markets Only	29	6.5	164	7.8
All Three Markets	279	62.6	545	25.9

Notes: (1) Issuers represents companies (for example, NAIC company codes). (2) Licensed Entities represents company/state combinations. (3) Total issuers excludes data for companies that are regulated by the California Department of Managed Health Care. (4) To be counted as offering coverage in a particular comprehensive major medical market, the issuer must have reported non-zero premiums and claims and had at least \$1,000 in total premiums per life year for at least one state. (5) Small group is defined based on the current definition in the PHS Act. (6) Subcategories do not add to the total because other categories are not shown separately such as those entities in the large group and small group markets, but not in the individual market.

Source: ASPE analysis of 2011 NAIC Supplemental Health Care Exhibit data.

b. Individuals

Persons enrolled in non-grandfathered individual or small group market coverage inside or outside of the Exchanges beginning in 2014 will be affected by the provisions of this proposed rule.²⁹

In July 2012, CBO estimated that there will be approximately 23 million enrollees in Exchange coverage by 2016.³⁰ Participation rates among potential enrollees are expected to be lower in the first few years of Exchange availability as employers and individuals adjust to the features of the Exchanges.³¹ Additionally, the EHB and AV provisions of this proposed rule will also affect enrollees in non-grandfathered individual and small group coverage outside of the Exchanges.

G. Anticipated Benefits

The Affordable Care Act ensures non-grandfathered health plans offered in the individual and small group markets

²⁹ As discussed earlier, the provisions in this proposed regulation could also potentially affect some enrollees with non-grandfathered large group market coverage in States that choose to give larger employers the option of purchasing coverage through the Exchange starting in 2017. However, the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) “expect that few large firms would take [advantage of] that option if offered because their administrative costs would generally be lower than those of nongroup policies that would be available in the exchanges.” (For more information, see Congressional Budget Office, “Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act,” Washington, DC, 2009).

³⁰ “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” Congressional Budget Office, July 2012.

³¹ Congressional Budget Office, “Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act,” Washington, DC, 2009.

offer a basic package of items and services. The benefits of health insurance coverage are well documented and discussed at length in previous RIAs,³² including improvement in clinical outcomes, financial security, and decreased uncompensated care.^{33, 34} This proposed rule applies a definition to EHB and proposes other standards that are required of health plans, as directed under the statute.

In the market today, it is difficult for consumers to make well-informed choices when choosing among competing health plans. The benefits offered are complicated and can vary widely across plans, making it difficult for consumers to understand which benefits are covered.³⁵ Further, wide

variation in deductibles, coinsurance, and other cost sharing features make it difficult for consumers to understand the relative levels of financial protection they will receive under competing plans.^{36, 37}

Under the provisions in this proposed rule, the EHB-benchmark plan will reflect both the scope of services and any limits offered by a “typical employer plan” in that state. This approach, applying for the 2014 and 2015 benefit years, will allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products. This should heighten consumer understanding of plan options and may facilitate consumers’ abilities to make choices that better suit their needs. In addition, by ensuring that all plans cover a core set of benefits and services that will be compared against other plans that offer the same financial protection to the consumer, this proposed rule is expected to improve the quality and value of the coverage that is available for EHB.

Information on AV is expected to be used by consumers to compare non-grandfathered individual and small group market plans, and provides a method for consumers to understand relative plan value. Proposing standard pricing and utilization assumptions for AV calculations for QHPs and non-grandfathered health plans in the individual and small group markets will promote transparency and simplicity in the consumer shopping experience, as well as offer issuers the flexibility to set cost-sharing rates that are simple and competitive. Without this approach,

³² Available at: <http://cciiio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf>.

³³ Institute of Medicine (2001). *Coverage Matters: Insurance and Health Care*. National Academies Press: Washington, DC. Burstin HR, Swartz K, O’Neil AC, Orav EJ, Brennan TA. 1999. The effect of change of health insurance on access to care. *Inquiry*; 35: 389–97. Finkelstein A et al. 2011. The Oregon health insurance experiment: Evidence from the first year. NBER Working Paper No. 17190

³⁴ Institute of Medicine (2002). *Care without coverage: too little, too late*. National Academies Press. Ayanian J, et al. “Unmet Health Needs of Uninsured Adults in the United States.” *JAMA*. 284(16). 2000:2061–9. 27; Roetzheim R, et al. “Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes.” *American Journal of Public Health* 90(11). 2000: 1746–54; Wilper, et al. “Health Insurance and Mortality in US Adults.” *American Journal of Public Health*. 99(12). 2009: 2289–2295.

³⁵ Garnick, D.W. et al. (1993). “How well do Americans understand their health coverage?” *Health Affairs*, 12(3); 204–212.

³⁶ Consumers Union. (2012). “What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans.” Available at: <http://www.consumersunion.org/pub/pdf/Consumer%20Difficulties%20Selecting%20Health%20Plans%20Jan%202012.pdf>.

³⁷ Isaacs, S.L. (2006). Consumer’s information needs: results of a national survey. *Health Affairs*, 15(4): 31–41.

plans with the same cost-sharing provisions could have different AVs making it difficult for consumers to compare and choose among health plans. It also fosters plan competition based on price, quality, and service—rather than variations in benefit design.

H. Anticipated Costs and Transfers

In addition to the administrative costs described in the Information Collection Requirements section of this proposed rule, HHS anticipates that the provisions of this proposed regulation will likely result in increased costs related to increased utilization of health care services by people receiving coverage for previously uncovered benefits.

States have primary enforcement authority over health insurance issuers and this proposed rule extends this primary enforcement authority for compliance with EHB and AV requirements defined in this rule. In addition, states must defray the cost of any state-required benefits in excess of the EHB that apply to QHPs and multi-state plans offered through Exchanges. As stated earlier, we expect that this will rarely occur, if at all, in 2014 and 2015, the period coverage by the benchmark policy.

The anticipated effects on enrollees in the individual market are expected to be larger than the effects on enrollees in the small group market. Coverage in the small group market is much more likely to include EHB and, in fact, is included in the choice of benchmark plans.³⁸ Second, almost all products in the group market have AV above 60 percent,³⁹ while there are likely to be changes to

³⁸ A study conducted by the Assistant Secretary for Planning and Evaluation (ASPE) found that commonly purchased products in the small group market, state employee plans, and federal employee plans do not differ significantly in the range of services they cover. Because one of these plans will be chosen as the reference plan for EHB, most small group plans will provide benefits that are similar to EHB. (ASPE Issue Brief (2011). “EHB: Comparing Benefits in Small Group Products and State and Federal Employee Plans.” U.S. Department of Health & Human Services.) In contrast, another ASPE study found that many current subscribers in the individual market lack coverage for some EHB benefits and services, such as maternity care and prescription drugs. (ASPE Research Brief (2011). “EHB: Individual Market Coverage” U.S. Department of Health & Human Services.)

³⁹ ASPE Research Brief (2011). “AV and Employer Sponsored Insurance,” available at: <http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf>. Similar results were found in a recent study by Gabel and colleagues. Jon R. Gabel, Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Slover and Ethan Levy-Forsythe, “More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014,” Health Affairs, (2012), available at: <http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.full.pdf+html>.

products in the individual market due to the provisions of this proposed rule.

Impact on Issuers

Commonly purchased products in the small group market, state employee plans, and the FEHBP Blue Cross Blue Shield (BCBS) Standard and Basic Options and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover.⁴⁰ Because one of these plans will be chosen as the reference plan for EHB, most small group plans will provide benefits that are similar to EHB, and changes in benefits offered to comply with EHB provisions will be relatively minor.

Notwithstanding this general conclusion, there are four types of benefits where changes are expected in the small group market: Mental health and substance use disorder, rehabilitative services, pediatric dental care, and pediatric vision services. In addition, individual health plans are less likely than small group health plans to cover all of the 10 categories of EHB. Below we discuss two categories of benefits and services that are less likely to be covered in the market today: Mental health and substance use disorder services, and rehabilitative services.

The coverage of additional benefits results in a transfer from out-of-pocket payments to premium payments. Increased access to insurance coverage for previously excluded benefits will make medical care for those benefit categories more affordable for consumers by covering a portion of the costs of those services. While out of pocket costs would decline, consumers could purchase benefits and services inefficiently—that is, purchase more than the efficient amount of the previously excluded benefits and services. However, studies of the Medicare program suggest that the costs of this inefficiency are likely more than offset by the benefits of risk reduction.⁴¹ Because the standards outlined in this proposed rule will likely result in incremental gains in access, rather than changes in status from uninsured to insured, any costs associated with any inefficiency, should be further reduced. As discussed previously, many other provisions of the Affordable Care Act,

⁴⁰ ASPE Issue Brief (2011). “EHB: Comparing Benefits in Small Group Products and State and Federal Employee Plans.” U.S. Department of Health & Human Services.

⁴¹ Finkelstein A, McKnight R: “What Did Medicare Do (And Was It Worth It)?” *Journal of Public Economics* 2008, 92:1644–1669; and Finkelstein, A, “The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare,” National Bureau of Economic Research Working Paper No. 11619, Sept, 2005.

including healthier risk pools, greater administrative efficiencies, premium tax credits, and the transitional reinsurance program will lower premiums in the individual market and Exchanges.

The statute requires that all plans covering EHB must offer mental health and substance use disorder service benefits, including behavioral health treatment and services. The preamble of this rule proposes that coverage must provide parity in treatment limitations between medical and surgical benefits and the mental health and substance use disorder benefits required to be covered as EHB in both the individual and small group markets. Many states^{42,43} have already added some form of mental health parity in some or all insured markets.⁴⁴ About 95 percent of those with coverage through the three largest small group products in each state had substance use disorder and mental health benefits.⁴⁵ Additionally, a study of implementation of parity in the FEHBP plans⁴⁶ as well as research into state-passed mental health parity laws⁴⁷ have shown little or no increase in utilization of mental health services, but found that parity reduced out-of-pocket spending among those who used mental health and substance abuse services.

As indicated in the preamble, many health insurance plans do not identify rehabilitative services as a distinct group of services.⁴⁸ By proposing a transitional policy for coverage of rehabilitative services, this rule allows issuers time for review and development of policy in this area, and to gain experience to define these benefits. To the extent that states

⁴² Kaiser State Health Facts. *State mandated benefits in small group private health insurance: Mandated coverage in mental health, as of January 2010*. Available at: <http://www.statehealthfacts.org/comparereport.jsp?rep=2&cat=7>.

⁴³ Health Insurance Mandates in the States 2010, Council for Affordable Health Insurance, available at: http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010ExecSummary.pdf.

⁴⁴ Health Insurance Mandates in the States 2010, Council for Affordable Health Insurance, available at: http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010ExecSummary.pdf.

⁴⁵ ASPE Issue Brief, “EHB: Comparing Benefits in Small Group Products and State and Federal Employee Plans, U.S. Department of Health & Human Services (2011).

⁴⁶ Goldman HH, et al. 2006. Behavioral health insurance parity for federal employees. *New Engl J Med*; 354 1378–86.

⁴⁷ Barry CL, Busch SH. 2007. Effects of state parity laws on the family financial burden of children with mental health care needs. *Health Serv Res*; 42: 1061–84. Ma CA, McGuire TG. 1998. Cost and incentives in a behavioral health carve-out. *Health Affairs*; 17: 56–67.

⁴⁸ ASPE Research Brief (2011). “EHB: Comparing Benefits in Small Group Products and State and Federal Employee Plans.” Available at: <http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml>.

exercise the option to define habilitative services, small group market issuers may incur administrative and contracting costs associated with bringing their products into compliance with a state's definition. However, because it is not yet clear which states will exercise this option or how any such states will define habilitative services, HHS cannot estimate these costs at this time.

With respect to AV, research indicates that the overwhelming majority of employer-sponsored health plans meets and exceeds an AV of 60 percent.⁴⁹ Combining both small group and large group, an estimated 1.6 percent to 2.0 percent of people covered by employer-sponsored insurance are enrolled in plans with an AV of less than 60 percent.

In the individual health insurance market, McKethan et al. estimated the percentage of individual market plans falling below 60 percent (the AV of a bronze plan), meaning that the health insurance coverage paid for less than 60 percent of benefit costs for the average enrollee, at between 9 percent and 11 percent.⁵⁰ To keep premium costs low, the Affordable Care Act allows certain individuals (adults under age 30 and people who otherwise have unaffordable coverage) to purchase catastrophic coverage, which still guarantees first dollar coverage of preventive services and primary care check-ups but has higher deductibles and lower AVs.

Costs to States

State governments are generally responsible for health insurance enforcement in the individual and small group markets, with the federal government assuming that role in connection with federal law requirements if a state does not do so. While HHS expects that states may need additional resources to enforce the requirements that non-grandfathered plans in the individual and small group market provide EHB, and that these plans offer coverage with an AV equal

to one of the four metal levels, these costs will be relatively minor. We request comment on the burden states will incur in enforcing these requirements.

If a state requires issuers to cover benefits in excess of EHB, the Affordable Care Act directs the state to defray the costs of these benefits in QHPs. States may include as part of their benchmark plan state benefit requirements that were enacted before December 31, 2011, avoiding costs associated with these provisions.

Costs to Health Insurance Issuers

Issuers will incur administrative costs to modify existing offerings to meet EHB and AV standards as defined in this proposed rule. For example, issuers that do not currently meet the standards for prescription drug coverage will incur contracting and one-time administrative costs to bring their pharmacy benefits into compliance. Issuers may also incur minor administrative costs related to AV standards and computing AV. However, because EHB will be based on a benchmark plan that is typical of what is offered in the market in each state currently, the modifications in benefits are expected to be relatively minor for most issuers. Further, issuers have extensive experience in offering products with various levels of cost sharing, and HHS expects that following the process for computing AV outlined in this proposed rule will not demand many additional resources.

I. Regulatory Alternatives

In addition to the regulatory approach outlined in the Essential Health Bulletin issued on December 16, 2011, HHS considered several alternatives when developing policy around defining EHBs and calculating AV.

Definition of EHBs

At the request of some commenters, HHS considered one national definition of EHB that would have applicable issuers offer a uniform list of benefits. However, this approach would not allow for state flexibility and issuer innovation in benefit design, would require a burdensome overhaul for issuers, and would disrupt the market.

HHS also considered codifying the 10 statutorily required categories without additional definition and allowing issuers to adjust their benefit packages accordingly. However, this approach would have allowed wide variation across plans in the benefits offered, would not have assured consumers that they would have coverage for basic benefits, and would not have improved

the ability of consumers to make comparisons among plans.

HHS believes the benchmark approach best strikes the balance between comprehensiveness, affordability, and state flexibility. Additionally, HHS believes that the benchmark approach, supplemented when necessary, best addresses the statutory requirements that EHBs reflect a typical employer plan and encompass at least the 10 categories of items and services outlined in the statute.

Calculation of AV

In the calculation of AV, the statute specifies the use of a standard population. As described in the AV/CSR Bulletin, HHS considered allowing issuers to use their own utilization and pricing data in connection with an HHS-defined standard population (that is, HHS-set demographics for the standard population) to calculate a standard population. However, this would not have allowed for consumer transparency and would not have increased competition. The approach in this proposed rule instead reduces issuer burden while allowing consumers to compare more easily among plans.

VI. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to analyze options for regulatory relief of small businesses if a proposed rule has a significant impact on a substantial number of small entities. The Act generally defines a "small entity" as (1) A proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of "small entity.") HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed above, this proposed rule is necessary to implement standards related to the EHB, AV, cost-sharing limitations, and quality, as authorized by the Affordable Care Act. For purposes of the Regulatory Flexibility Analysis, we expect the following types of entities to be affected by this proposed rule: (1) Issuers; (2) employers; and (3) providers.

We believe that health insurers would be classified under the North American Industry Classification System (NAICS) Code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average

⁴⁹ ASPE Research Brief (2011). "AV and Employer Sponsored Insurance," available at: <http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf>. Similar results were found in a recent study by Gabel and colleagues. Jon R. Gabel, Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Slover and Ethan Levy-Forsythe, "More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014," Health Affairs, (2012), available at: <http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.full.pdf+html>.

⁵⁰ Aaron McKethan, Mark Zezza, Lawrence Kocot, Mark Shepard, and Don Cohn, "Minimum Creditable Coverage," Bipartisan Policy Center, January 2010.

annual receipts of \$7 million or less would be considered small entities for this NAICS code. Health issuers could possibly also be classified in NAICS Code 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be \$10 million or less.

As discussed in the Web Portal interim final rule (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis we determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for “small” business

established by the SBA (currently \$7 million in annual receipts for health insurers, based on North American Industry Classification System Code 524114).⁵¹

For purposes of this proposed rule, HHS used 2011 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and small group markets. HHS used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. Table IV.3 shows that HHS estimates that there were 35 small entities with less than \$7 million in accident and health earned premiums offering individual or small group comprehensive major medical (CMM) coverage; however, this estimate

may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies’ other lines of business.

HHS estimates that 83 percent of these small issuers are subsidiaries of larger carriers, and 71 percent also offer large group or other types of A&H coverage. On average, HHS estimates that individual and small group CMM coverage accounts for approximately 45 percent of total A&H earned premiums for these small issuers. HHS estimates that 75 percent of these small issuers only offer individual and small group CMM coverage in a single state. Additionally, HHS estimates that approximately a third (11) of these small issuers only offer individual market CMM coverage.

TABLE IV.3—DESCRIPTION OF ISSUERS OFFERING INDIVIDUAL OR SMALL GROUP COMPREHENSIVE MAJOR MEDICAL (CMM) COVERAGE BY SIZE, 2011

Total earned premiums for accident and health coverage	Total issuers offering individual or small group market CMM coverage	Percent of issuers that are part of larger carriers	Average number of states in which individual or small group CMM coverage is offered	Percent of issuers only offering individual or small group CMM coverage in a single state	Individual & small group CMM premiums as a percent of total A&H premiums	Percent of issuers also offering large group CMM or other A&H coverage	Number of issuers only offering individual market CMM coverage
Less Than \$7 Million	35	82.9	2.3	74.3	45.0	71.4	11
\$7 million to \$99 million	93	68.8	4.5	62.4	37.2	66.7	6
\$100 million to \$999 billion	184	87.0	5.2	65.8	27.0	84.8	11
\$1 billion or more	115	87.8	4.8	69.6	24.0	93.9	1
Total	427	82.9	4.7	66.7	24.5	82.2	29

Notes: (1) Issuers represents companies (for example, NAIC company codes). (2) Licensed Entities represents company/state combinations. (3) Total issuers excludes data for companies that are regulated by the California Department of Managed Health Care. (4) To be counted as offering coverage in a particular comprehensive major medical market, the issuer must have reported positive premiums, non-zero claims and had at least \$1,000 in total premiums per life year for at least one state. (5) Small group is defined based on the current definition in the PHS Act.

Sources: ASPE analysis of 2011 NAIC Supplemental Health Care Exhibit data.

This rule proposes standards related to EHBs, AV, and accreditation. These standards may impose some additional costs on issuers offering coverage that is affected by these provisions. For example, as discussed earlier, issuers are likely to experience some administrative costs associated with reconfiguring existing non-grandfathered plans to meet EHB and AV metal level standards as defined in this proposed rule. However, these costs will vary depending on a number of factors, including the extent to which an issuer offers coverage in multiple states or is a subsidiary of a larger carrier, and the variation between these standards and current practice. Further, some of the changes that standardize coverage may reduce administrative costs.

Accordingly, we cannot estimate an effect on premiums with precision prior to final state selection of benchmarks.

As discussed in the regulatory impact analysis for the Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers final rule (77 FR 18310 (Mar. 27, 2012)), the cost of participating in an Exchange is an investment for QHP issuers, with benefits expected to accrue to QHP issuers because of access to new markets where consumers may receive generous tax credits to purchase insurance.

This proposed rule also establishes standards that will affect employers participating in the small group market, including those that choose to participate in a SHOP. As discussed in the Summary of Regulatory Impact

Analysis for the Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers final rule, the SHOP is limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many affected employers would meet the SBA standard for small entities. However, the standards outlined in this proposed rule apply to issuers of small group market health insurance coverage, and not to any small employers that elect to purchase such coverage on behalf of their employees (that is, the proposed rule impacts what coverage is available to be purchased). We anticipate that the essential health benefits, coupled with the ability to compare plans based on metal level, will lead to greater

⁵¹ “Table of Size Standards Matched to North American Industry Classification System Codes,”

effective November 5, 2010, U.S. Small Business Administration, available at <http://www.sba.gov>.

transparency and reduce transaction costs for small employers.

HHS anticipates that the provisions in this proposed rule will have a positive effect on providers—particularly those offering services in areas where many individual market enrollees previously did not have coverage for these services, and those who serve a substantial share of the low-income population. HHS anticipates that small providers will also experience positive effects relating to the provisions of this proposed rule.

Therefore, the Secretary certifies that this proposed rule will not have a significant impact on a substantial number of small entities. We welcome comment on the analysis described in this section and on HHS's conclusion.

VII. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any proposed rule that includes a federal mandate that could result in expenditure in any one year by state, local or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold level is approximately \$139 million.

UMRA does not address the total cost of a proposed rule. Rather, it focuses on certain categories of cost, mainly those "Federal mandate" costs resulting from: (1) Imposing enforceable duties on state, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs.

Because states are not required to set up an Exchange, and because grants are available for funding of the establishment of an Exchange by a state, we anticipate that this final rule would not impose costs above that threshold on state, local, or Tribal governments. In addition, because states largely already collect information on plan rates and benefits to license them, we believe that the burden on states is limited. However, because these costs have not been estimated, HHS seeks comments on any additional burdens.

Under the proposed rule, issuers will provide coverage of certain benefits. While some issuers may not currently offer benefit packages that meet the standards outlined in the proposed rule, we anticipate that the administrative costs associated with compliance will fall below the threshold. We anticipate that such administrative costs will be concentrated in the initial year, with

costs significantly tapering off during subsequent years.

The benchmark-based approach to defining EHB ensures that EHB will reflect the scope of services offered by a "typical employer plan." Accordingly, we anticipate that many small group market plans meet or are close to meeting the coverage requirements for EHB and will not need to incur significant administrative costs to bring currently available plans into compliance. Individual market plans are somewhat less likely to cover all statutorily required benefits and services as described in this proposed rule; however, many such plans are offered by issuers with diverse portfolios that may include small and large group products or other individual market products that do include the required services. Accordingly, we do not anticipate that the provisions related to the EHB package outlined in the proposed rule impose costs greater than \$139 million on the private sector.

Consistent with policy embodied in UMRA, this notice for proposed rulemaking has been designed to be the least burdensome alternative for state, local and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

VIII. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications.

States regulate health insurance coverage. States would continue to apply state laws regarding health insurance coverage. However, if any state law or requirement prevents the application of a Federal standard, then that particular state law or requirement would be preempted. State requirements that are more stringent than the Federal requirements would not be preempted by this proposed rule unless such requirements prevent the application of Federal law. Accordingly, states have significant latitude to impose requirements with respect to health insurance coverage that are more consumer-protective than the Federal law.

In the view of HHS, this proposed rule does not impose substantial direct costs on state and local governments. However, we believe that this proposed rule has Federalism implications due to direct effects on the distribution of power and responsibilities among the state and Federal governments relating

to determining standards for health insurance coverage that is offered in the individual and small group markets. Each state would adhere to the federal standards outlined in the proposed rule for purposes of determining whether non-grandfathered individual and small group market health insurance coverage includes the EHB package, or have HHS enforce these policies.

HHS expects that the federalism implications, if any, are substantially mitigated for a number of reasons. First, the proposed rule affords discretion to states to select an EHB-benchmark plan. States also can choose to be responsible for evaluating the selected benchmark and making adjustments as needed, and for determining whether non-grandfathered individual and small group market health insurance coverage meets the standards outlined in the proposed rule. While the proposed rule establishes new federal standards for certain health insurance coverage, states will retain their traditional regulatory roles. Further, if a state elects not to substantially enforce the standards outlined in the final rule, the Federal government will assume responsibility for these standards.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of the states, HHS has made efforts to consult with and work cooperatively with states as evidenced by continued communication through weekly calls and listening sessions.

HHS initiated weekly calls with key stakeholders from states in April 2010 as a way for HHS and states to have a regular means of communication about the Affordable Care Act. The audience for the call is "State Government Implementers of the Affordable Care Act" which often includes Governors' office staff, state Medicaid Directors' staff, Insurance Commissioners' staff, state high risk pool staff, Exchange grantees, health reform coordinators, and other state staff. National intergovernmental organizations are also invited to participate. Regular participants also include representatives from the following intergovernmental organizations:

- National Governors Association
- National Conference of State Legislatures
- National Association of Medicaid Directors
- National Association of Insurance Commissioners
- American Public Human Services Association

- The Council of State Governments
- National Academy for State Health Policy
- National Association of Counties

These calls, in addition to listening sessions specifically related to EHB, have helped HHS understand states' major concerns about implementation of the Affordable Care Act. Continuous communication with states allowed HHS to develop policy that addressed two central concerns: flexibility and state-required benefits. The benchmark approach allows states to select a benchmark option that offer benefit packages that reflect the needs of their populations and maintain state-required benefits that were enacted before December 31, 2011. This approach minimizes state burden while increasing access to quality health care.

List of Subjects

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, state regulation of health insurance.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, state and local governments, Technical assistance, Women, and Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory Committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, state and local governments, Sunshine Act, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 147, 155, and 156 as set forth below:

Subchapter B—Requirements Relating to Health Care Access

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. The authority citation for part 147 continues to read as follows:

Authority: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

2. Section 147.150 is added to read as follows:

§ 147.150 Coverage of essential health benefits.

(a) *Requirement to cover the essential health benefits package.* A health insurance issuer offering health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package as defined in section 1302(a) of the Affordable Care Act effective for plan or policy years beginning on or after January 1, 2014.

(b) *Cost-sharing under group health plans.* [Reserved.]

(c) *Child-only plans.* If a health insurance issuer in the individual market offers health insurance coverage in any level of coverage specified under section 1302(d)(1) of the Affordable Care Act, the issuer must offer coverage in that level to individuals who, as of the beginning of a plan year, have not attained the age of 21.

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

3. The authority citation for part 155 is revised to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1402, 1411, 1412, 1413, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18033, 18041-18042, 18051, 18054, 18071, and 18081-18083).

4. Adding § 155.170 to subpart B to read as follows:

§ 155.170 Additional required benefits.

(a) *Additional required benefits.* (1) A state may require a QHP to offer benefits in addition to the essential health benefits.

(2) A state-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits.

(3) The Exchange shall identify which state-required benefits are in excess of EHB.

(b) *Payments.* The state must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:

(1) To an individual enrollee, as defined in § 155.20 of this subchapter;

or

(2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.

(c) *Cost of additional required benefits.* (1) Each QHP issuer in the state shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section.

(2) A QHP issuer's calculation shall be:

(i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(ii) Conducted by a member of the American Academy of Actuaries; and

(iii) Reported to the Exchange.

5. Revise § 155.1045 to read as follows:

§ 155.1045 Accreditation timeline.

(a) *Timeline.* The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subchapter, except for multi-state plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-state plans.

(b) *Federally-facilitated Exchange.* The accreditation timeline used in Federally-facilitated Exchanges follows:

(1) During certification for an issuer's initial year of QHP certification (for example, in 2013 for the 2014 coverage year), a QHP issuer without existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is applying to offer coverage must have scheduled or plan to schedule a review of QHP policies and procedures of the applying QHP issuer with a recognized accrediting entity.

(2) Prior to a QHP issuer's second year and third year of QHP certification (for example, in 2014 for the 2015 coverage year and 2015 for the 2016 coverage year), a QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products or, a QHP issuer must have commercial or Medicaid health plan accreditation granted by a recognized accrediting entity for the same State in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that

accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP.

(3) Prior to the QHP issuer's fourth year of QHP certification and in every subsequent year of certification (for example, in 2016 for the 2017 coverage year and forward), a QHP issuer must be accredited in accordance with § 156.275 of this subchapter.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

6. The authority citation for part 156 is revised to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321–1322, 1324, 1334, 1342–1343, and 1401–1402, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, and 26 U.S.C. 36B).

7. Amend § 156.20 by adding definitions for “Actuarial value (AV),” “Base-benchmark plan,” “EHB-benchmark plan,” “EHB package,” and “Percentage of the total allowed costs of benefits” in alphabetical order to read as follows:

§ 156.20 Definitions.

* * * * *

Actuarial value (AV) means the percentage paid by a health plan of the percentage of the total allowed costs of benefits.

* * * * *

Base-benchmark plan means the plan that is selected by a state from the options described in § 156.100(a) of this subchapter, or a default benchmark plan, as described in § 156.100(c) of this subchapter, prior to any adjustments made pursuant to the benchmark standards described in § 156.110 of this subchapter.

* * * * *

EHB-benchmark plan means the standardized set of essential health benefits that must be met by a QHP, as defined in § 155.20 of this section, or other issuer as required by § 147.150 of this subchapter.

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 of this subchapter; 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.

* * * * *

Percentage of the total allowed costs of benefits means the anticipated covered medical spending for EHB coverage (as defined in § 156.110(a) of this subchapter) 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.

* * * * *

8. Revise subpart B to read as follows:

Subpart B—Essential Health Benefits package

Sec.

- 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.
- 156.120 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, 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 U.S.C. 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 in the state's small group market.

§ 156.105 Determination of EHB for multi-state plans.

A Multi-State Plan must meet benchmark standards set by the U.S. Office of Personnel Management.

§ 156.110 EHB-benchmark plan standards.

General requirements. 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.

(b) *Coverage in each benefit category.* A base-benchmark plan not providing any coverage in one or more of the categories described in paragraph (a) of this section, must be supplemented as follows:

(1) *General supplementation methodology.* A base-benchmark plan that does not include items or services within one or more of the categories described in paragraph (a) of this section must be supplemented by the addition of the entire category of such benefits offered under any other benchmark plan option described in § 156.100(a) of this subpart unless otherwise described in this subsection.

(2) *Supplementing pediatric oral services.* A base-benchmark plan lacking the category of pediatric oral services must be supplemented by the addition of the entire category of benefits from one of the following:

- (i) The FEDVIP dental plan with the largest national enrollment that is

described in and offered to federal employees under 5 U.S.C. 8952; or

(ii) The benefits available under that state's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(3) *Supplementing pediatric vision services.* A base-benchmark plan lacking the category of pediatric vision services must be supplemented by the addition of the entire category of such benefits from one of the following:

(i) The FEDVIP vision plan with the largest national enrollment that is offered to Federal employees under 5 U.S.C. 8982; or

(ii) The benefits available under the state's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(c) *Supplementing the default base-benchmark plan.* A default base-benchmark plan as defined in § 156.100(c) of this subpart that lacks any categories of essential health benefits will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category:

(1) The largest plan by enrollment in the second largest product in the state's small group market, as defined in § 155.20 of this subchapter (except for pediatric oral and vision benefits);

(2) The largest plan by enrollment in the third largest product in the state's small group market, as defined in § 155.20 of this subchapter (except for pediatric oral and vision benefits);

(3) The largest national FEHBP plan by enrollment across states that is offered to federal employees under 5 U.S.C. 8903 (except for pediatric oral and vision benefits);

(4) The plan described in paragraph (b)(2)(i) of this section with respect to pediatric oral care benefits;

(5) The plan described in paragraph (b)(3)(i) of this section with respect to pediatric vision care benefits; and

(6) A habilitative benefit determined by the plan as described in § 156.115(a)(4) of this subpart or by the state as described in paragraph (f) of this section.

(d) *Non-discrimination.* Not include discriminatory benefit designs that contravene the non-discrimination standards defined in § 156.125 of this subpart.

(e) *Balance.* Ensure an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.

(f) *Determining habilitative services.* If the base-benchmark plan does not include coverage for habilitative services, the state may determine which services are included in that category.

§ 156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of § 156.120 of this subpart;

(2) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under § 156.110(a)(5) of this subpart, comply with the requirements of § 146.136 of this subchapter.

(3) Include preventive health services described in § 147.130 of this subchapter.

(4) If the EHB-benchmark plan does not include coverage for habilitative services, as described in § 156.110(f) of this subpart, a plan must include habilitative services that meet one of the following—

(i) Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or

(ii) Are determined by the issuer and reported to HHS.

(b) Benefit substitution is allowed if the issuer of a plan offering EHB meets the following conditions—

(1) Substitutes a benefit that meets the following conditions:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(3) of this section;

(ii) Is made only within the same essential health benefit category; and

(iii) Is not a prescription drug benefit.

(2) Submits evidence of actuarial equivalence of substituted benefits to the state. The certification must:

(i) Be conducted by a member of the American Academy of Actuaries;

(ii) Be based on an analysis performed in accordance with generally accepted actuarial principles and methodologies; and

(iii) Use a standardized plan population;

(3) Actuarial equivalence of benefits is determined regardless of cost-sharing.

(c) A health plan does not fail to provide EHB solely because it does not offer the services described in § 156.280(d) of this subchapter.

(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or cosmetic orthodontia as EHB.

§ 156.120 Prescription drug benefits.

(a) A health plan does not provide essential health benefits unless it:

(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

(i) One drug in every United States Pharmacopeia (USP) category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the Exchange, the state, or OPM.

(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs for services described in § 156.280(d) of this subchapter.

(c) A health plan providing essential health benefits must have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan.

§ 156.125 Prohibition on discrimination.

(a) 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; and

(b) An issuer providing EHB must comply with the requirements of § 156.200(e) and § 156.225 of this subchapter.

§ 156.130 Cost-sharing requirements.

(a) *Annual limitation on cost sharing.*

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

(i) For self-only coverage—the annual dollar limit as described in section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that is in effect for 2014; or

(ii) For other than self-only coverage—the annual dollar limit in section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.

(2) 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 limit if that plan may not reasonably reach the actuarial value of a given level of coverage as defined in § 156.140 of this subpart without exceeding the annual deductible limit.

(c) *Special rule for network plans.* In the case of a plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not count towards the annual limitation on cost sharing (as defined in paragraph (a) of this section), or the annual limitation on deductibles (as defined in paragraph (b) of this section).

(d) *Increase annual dollar limits in multiples of 50.* For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in paragraphs (a) and (b) of this section that do not result in a multiple of 50 dollars must be rounded to the next lowest multiple of 50 dollars.

(e) *Premium adjustment percentage.* The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.

(f) *Coordination with preventive limits.* Nothing in this subpart is in derogation of the requirements of § 147.130 of this subchapter.

(g) *Prohibition of discriminatory cost sharing.* The structure of cost sharing required under a plan must conform to the nondiscrimination requirements applicable to benefits set forth in § 156.125 of this subpart.

(h) *Coverage of emergency department services.* Emergency department services must be provided as follows:

(1) Without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

(2) If such services are provided out-of-network, cost-sharing must be limited as provided in § 147.138(b)(3) of this subchapter.

§ 156.135 AV calculation for determining level of coverage.

(a) *Calculation of AV.* Subject to paragraph (b) of this section, to calculate the AV of a health plan, the issuer must use the AV calculator developed and made available by HHS.

(b) *Exception to the use of the AV calculator.* If a health plan's design is not compatible with the AV calculator, the issuer must meet the following:

(1) Submit the actuarial certification on the chosen methodology identified in paragraphs (b)(2) and (3) of this section:

(2) Calculate the plan's AV by:

- (i) Estimating a fit of its plan design into the parameters of the AV calculator; and

- (ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(3) Use the AV calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries calculate, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator.

(4) The calculation methods described in (b)(2) or (3) of this section may include only in-network cost-sharing, including multi-tier networks.

(c) *Employer contributions to health savings accounts and amounts made available under health reimbursement arrangements.* In plans other than those in the individual market that are offered with an HSA or HRA, annual employer contributions to HSAs and amounts newly made available under HRAs for the current year in the small group market are:

(1) Counted towards the total anticipated medical spending of the

standard population that is paid by the health plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

- (i) Any current year HSA contributions are accounted for; and
- (ii) The amounts newly made available under an HRA for the current year are accounted for.

(d) *Use of state-specific standard population for the calculation of AV.* Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set will be used as the standard population to calculate AV in accordance with paragraph (a) of this section. The data set may be approved by HHS if it is submitted in accordance with paragraph (e) of this section and:

(1) Supports the calculation of AVs for the full range of health plans available in the market;

(2) Is derived from a non-elderly population and estimates those likely to be covered by private health plans on or after January 1, 2014;

(3) Is large enough that:

- (i) The demographic and spending patterns are stable over time; and
- (ii) Includes a substantial majority of the state's insured population, subject to the requirement in paragraph (d)(2) of this section;

(4) Is a statistically reliable and stable basis for area-specific calculations; and

(5) Contains claims data on health care services typically offered in the then-current market.

(e) *Submission of state-specific data.* AV will be calculated using the default standard population described in paragraph (f) of this section, unless a data set in a format specified by HHS that can support the use of the AV calculator as described in paragraph (a) of this section is submitted by a state and approved by HHS consistent with paragraph (d) of this section by a date specified by HHS.

(f) *Default standard population.* The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in paragraph (a) of this section.

§ 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) *Levels of coverage.* 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.

(c) De minimis variation. The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is +/- 2 percentage points.

§ 156.145 Determination of minimum value.

(a) Acceptable methods for determining MV. For the purposes of determining that an employer-sponsored plan provides MV, a group health plan may use the following methods to calculate the percentage of the total allowed costs of benefits provided under the plan or coverage:

(1) The MV calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under the rules in paragraph (b) of this section.

(2) Any safe harbor established by HHS and the Internal Revenue Service.

(3) A group health plan may seek an appropriate certification by an actuary to determine MV if neither of the methods described in paragraphs (a)(1) or (2) of this section is appropriate. The determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

(b) Benefits that may be counted towards the determination of MV. (1) In the event that a group health plan uses the MV calculator and offers an EHB outside of the parameters of the MV calculator, the plan may seek an actuary, who is a member of the American Academy of Actuaries, to determine the value of that benefit and adjust the result derived from the MV calculator to reflect that value.

(2) For this purpose of the options described in this subsection in determining MV, a group health plan will be permitted to take into account all benefits provided by the plan that are included in any of the EHB benchmarks.

(c) Standard population. The standard population for MV determinations described in paragraph (a) of this section is the standard population developed by HHS for such use and described through summary statistics issued by HHS. The standard population for MV shall reflect the

population covered by self-insured group health plans.

§ 156.150 Application to stand-alone dental plans inside the Exchange.

(a) Annual limitation on cost-sharing. A stand-alone dental plan covering the pediatric dental EHB under § 155.1065 of this subchapter must demonstrate to the Exchange that it has a reasonable annual limitation on cost-sharing. Such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services.

(b) Calculation of AV. A stand-alone dental plan:

(1) May not use the AV calculator in § 156.135 of this subpart;

(2) Must demonstrate that the stand-alone dental plan offers the pediatric dental essential health benefit at either:

(i) A low level of coverage with an AV of 75 percent; or

(ii) A high level of coverage with an AV of 85 percent; and

(iii) Within a de minimis variation of +/- 2 percentage points of the level of coverage in paragraphs (b)(2)(i) or (ii) of this section.

(3) The level of coverage as defined in paragraph (b)(2) of this section must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.

9. In § 156.275, revise paragraphs (c)(1), (c)(4) introductory text, and (c)(4)(i) to read as follows:

§ 156.275 Accreditation of QHP Issuers.

(c) * * *

(1) Recognition of accrediting entity by HHS—(i) Application. An accrediting entity may apply to HHS for recognition. An application must include the documentation described in paragraph (c)(4) of this section and demonstrate, in a concise and organized fashion how the accrediting entity meets the requirements of paragraphs (c)(2) and (3) of this section.

(ii) Proposed notice. Within 60 days of receiving a complete application as described in paragraph (c)(1)(i) of this section, HHS will publish a notice in the **Federal Register** identifying the accrediting entity making the request, summarizing HHS's analysis of whether the accrediting entity meets the criteria described in paragraphs (c)(2) and (3) of this section, and providing no less than a 30-day public comment period about whether HHS should recognize the accrediting entity.

(iii) Final notice. After the close of the comment period described in paragraph (c)(1)(ii) of this section, HHS will notify the public in the **Federal Register** of the

names of the accrediting entities recognized and those not recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs.

(iv) Other recognition. Effective upon completion of conditions listed in paragraphs (c)(2), (3), and (4) of this section, HHS will notify the public in the **Federal Register**, that the National Committee for Quality Assurance (NCQA) and URAC are recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs meeting the requirements of this section.

* * * * *

(4) Documentation. An accrediting entity applying to be recognized under the process described in (c)(1) of this section must provide the following documentation:

(i) To be recognized, an accrediting entity must provide current accreditation standards and requirements, processes and measure specifications for performance measures to demonstrate that it meets the conditions described in paragraphs (c)(2) and (3) of this section to HHS.

* * * * *

Dated: August 1, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 14, 2012.

Kathleen Sebelius,

Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations:

Appendix A: List of Proposed Essential Health Benefits Benchmarks

The purpose of this appendix is to list the proposed EHB benchmark plans for the 50 states and the District of Columbia for public review and comment. As described in the EHB Bulletin published December 16, 2011, and proposed in § 156.100 of this regulation, each state may select a benchmark plan to serve as the standard for plans required to offer EHB in the state.⁵² HHS has also proposed that the default benchmark plan for states that do not exercise the option to select a benchmark health plan would be the largest plan by enrollment in the largest product in the state's small group market. As described in proposed § 156.110, an EHB-benchmark plan must offer coverage in each of the 10 statutory benefit categories. In the summary table that follows, we list the proposed EHB benchmark plans. Additional information on

⁵² Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges along with certain other types of plans must cover EHBs beginning in 2014. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

the specific benefits, limits, and prescription drug categories and classes covered by the EHB-benchmark plans, and state-required

benefits, is provided on the Center for Consumer Information and Insurance

Oversight (CCIIO) Web site (<http://ccio.cms.gov/resources/data/ehb.html>).

State	Plan type	Issuer and plan name	Supplemented categories	Supplementary plan type	Habilitative services
Alabama	Largest small group product.	Blue Cross Blue Shield of Alabama PPO 320 Plan.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	Yes.
Alaska	Largest small group product.	Premera Blue Cross Blue Shield of Alaska Heritage Select Envoy PPO.	Mental health and substance use disorder, including behavioral health treatment. Pediatric oral Pediatric vision	Largest FEHBP FEDVIP. FEDVIP.	Yes.
Arizona	Largest state employee plan.	Arizona Benefit Options EPO Plan, administered by United HealthCare.	Pediatric oral Pediatric vision	FEDVCP. FEDVIP	No.
Arkansas	Plan from 3rd largest small group product.	HMO Partners, Inc. Open Access POS, 13262AR001.	Mental health and substance use disorder, including behavioral health treatment. Pediatric oral Pediatric vision	2nd largest FEHBP CHIP. FEDVIP.	No.
California	Plan from largest small group product.	Kaiser Foundation Health Plan, Inc. Small Group HMO 30 ID 40513CA035.	Pediatric oral	CHIP	Yes.
Colorado	Plan from largest small group product.	Kaiser Foundation Health Plan of Colorado Ded HMO 1200D.	Pediatric oral	CHIP	No.
Connecticut	Largest state non-Medicaid HMO.	ConnectiCare HMO	Pediatric oral Pediatric vision	CHIP FEDVIP.	No.
Delaware	Plan from second largest small group product.	Highmark Blue Cross Blue Shield Delaware Simply Blue EPO 100 500.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	No.
District of Columbia	Plan from largest small group product.	Group Hospitalization and Medical Services, Inc. BluePreferred PPO.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	Yes.
Florida	Plan from largest small group product.	Blue Cross Blue Shield of Florida, Inc. BlueOptions PPO.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	No.
Georgia	Plan from largest small group product.	Blue Cross Blue Shield of Georgia HMO Urgent Care 60 Copay.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	Yes.
Hawaii	Plan from largest small group product.	Hawaii Medical Service Association Preferred Provider Plan 2010.	Pediatric oral Pediatric vision	CHIP FEDVIP.	No.
Idaho	Plan from largest small group product.	Blue Cross of Idaho Health Service, Inc. Preferred Blue PPO.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	Yes.
Illinois	Plan from largest small group product.	Blue Cross and Blue Shield of Illinois BlueAdvantage PPO.	Pediatric oral	CHIP	No.

State	Plan type	Issuer and plan name	Supplemented categories	Supplementary plan type	Habilitative services
			Pediatric vision	FEDVIP.	
Indiana	Plan from largest small group product.	Anthem Blue Cross and Blue Shield of Indiana Blue 5 Blue Access PPO Medical Option 6 Rx Option G.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Iowa	Plan from largest small group product.	Wellmark Inc. Alliance Select Copayment Plus PPO.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Kansas	Plan from largest small group product.	Blue Cross and Blue Shield of Kansas Comprehensive Major Medical Blue Choice PPO GF 500 deductible with Blue Rx card.	Pediatric oral	FEDVIP	No.
			Pediatric vision	FEDVIP.	
Kentucky	Plan from largest small group product.	Anthem Health Plans of Kentucky, Inc. PPO.	Pediatric oral	CHIP	Yes.
Louisiana	Plan from largest small group product.	Blue Cross and Blue Shield of Louisiana GroupCare PPO.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Maine	Plan from largest small group product.	Anthem Health Plans of Maine Blue Choice 20 PPO with RX 10 30 50 50.	Pediatric oral	FEDVIP	Yes.
Maryland	Largest state employee plan.	CareFirst of Maryland, Inc. State of Maryland PPO.	Pediatric oral	CHIP	Yes.
			Pediatric vision	FEDVIP.	
Massachusetts	Plan from largest small group product.	Blue Cross Blue Shield of Massachusetts, Inc. HMO Blue 2000 Deductible.	Pediatric oral	CHIP	Yes.
Michigan	Largest state non-Medicaid HMO.	Priority Health PriorityHMO 100 Percent Hospital Services Plan.	Pediatric oral	CHIP	No.
			Pediatric vision	FEDVIP.	
Minnesota	Plan from largest small group product.	HealthPartners 500 25 Open Access PPO.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Mississippi	Plan from largest small group product.	Blue Cross and Blue Shield of Mississippi Network Blue PPO.	Pediatric oral	CHIP	Yes.
			Pediatric vision	FEDVIP.	
Missouri	Plan from largest small group product.	Healthy Alliance Life Insurance Co. (Anthem BCBS) Blue 5 Blue Access PPO Medical Option 4 Rx Option D.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Montana	Plan from largest small group product.	Blue Cross and Blue Shield of Montana Blue Dimensions PPO.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Nebraska	Plan from largest small group product.	Blue Cross and Blue Shield of Nebraska BluePride PPO.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Nevada	Plan from largest small group product.	Rocky Mountain Hospital & Medical Service, Inc. (Anthem BCBS) GenRx PPO 45 Copay.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	

State	Plan type	Issuer and plan name	Supplemented categories	Supplementary plan type	Habilitative services
New Hampshire	Plan from largest small group product.	Matthew Thornton Health Plan (Anthem BCBS) HMO Blue New England 25 50 WITH Rx 10 35 30 OOP 2500.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
New Jersey	Plan from largest small group product.	Horizon HMO Access HSA Compatible	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
New Mexico	Plan from largest small group product.	Lovelace Insurance Company Classic PPO.	Pediatric oral	CHIP	Yes.
New York	Plan from largest small group product.	Oxford Health Insurance, Inc. Oxford EPO.	Pediatric oral	CHIP	Yes.
North Carolina	Plan from largest small group product.	Blue Cross and Blue Shield of North Carolina Blue Options PPO.	Pediatric oral	FEDVIP	No.
			Pediatric vision	FEDVIP.	
North Dakota	Largest state non-Medicaid HMO.	Sanford Health Plan HMO	Pediatric oral	CHIP	No.
			Pediatric vision	CHIP.	
Ohio	Plan from largest small group product.	Community Insurance Company (Anthem BCBS) Blue 6 Blue Access PPO Medical Option D4 Rx Option G.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Oklahoma	Plan from largest small group product.	Blue Cross and Blue Shield of Oklahoma BlueOptions PPO RYB05.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Oregon	Plan from 3rd largest small group product.	PacificSource Health Plans PPO Preferred CoDeduct Value 3000 35 70.	Pediatric oral	CHIP	No.
			Pediatric vision	FEDVIP.	
Pennsylvania	Plan from largest small group product.	Aetna Health, Inc. PA POS Cost Sharing 34 1500 Ded.	Pediatric oral	FEDVIP	No.
Rhode Island	Plan from largest small group product.	Blue Cross and Blue Shield of Rhode Island Vantage Blue PPO.	Pediatric oral	FEDVIP	No.
			Pediatric vision	FEDVIP.	
South Carolina	Plan from largest small group product.	Blue Cross Blue Shield of South Carolina Business Blue Complete PPO.	Pediatric oral	FEDVIP	No.
			Pediatric vision	FEDVIP.	
South Dakota	Plan from largest small group product.	Wellmark of South Dakota Blue Select PPO.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Tennessee	Plan from largest small group product.	Blue Cross Blue Shield of Tennessee PPO.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	
Texas	Plan from largest small group product.	Blue Cross Blue Shield of Texas BestChoice PPO RS26.	Pediatric oral	FEDVIP	Yes.
			Pediatric vision	FEDVIP.	

State	Plan type	Issuer and plan name	Supplemented categories	Supplementary plan type	Habilitative services
Utah	Plan from 3rd largest state employee plan.	Public Employee's Health Program Utah Basic Plus.	None	None	Yes.
Vermont	Plan from largest small group product.	The Vermont Health Plan, LLC, CDHP-HMO.	Pediatric oral Pediatric vision	CHIP FEDVIP.	No.
Virginia	Plan from largest small group product.	Anthem Health Plans of VA PPO KeyCare 30 with KC30 Rx plan 10 30 50 OR 20.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	Yes.
Washington	Plan from largest small group product.	Regence BlueShield non-grandfathered small group product.	Pediatric oral Pediatric vision	CHIP FEDVIP.	Yes.
West Virginia	Plan from largest small group product.	Highmark Blue Cross Blue Shield West Virginia Super Blue PPO Plus 2000 1000 Ded.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	No.
Wisconsin	Plan from largest small group product.	UnitedHealthcare Insurance Company Choice Plus Definity HSA Plan A92NS.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	No.
Wyoming	Plan from largest small group product.	Blue Cross Blue Shield of Wyoming Blue Choice Business 1000 80 20.	Pediatric oral Pediatric vision	FEDVIP FEDVIP.	No.

Note: If the base-benchmark plan does not include habilitative services, then states have the opportunity to define those benefits.

Appendix B: Largest FEDVIP Dental and Vision Plan Options, as of March 31, 2012

Section 156.110(b)(2)-(3) directs States to supplement base-benchmark plans that lack pediatric oral or vision services with benefits drawn from either the Federal Employees

Dental and Vision Program (FEDVIP) or a state's separate CHIP program. Specifically, states may select benefits from either: (1) The FEDVIP dental or vision plans with the largest national enrollments, or (2) the state's separate CHIP program's dental or vision benefits, where they exist, which offer benefits to the eligibility group with the

highest enrollment. To assist states with this process, we collected information about the benefits provided in the FEDVIP dental and vision plans with the highest national enrollments, as issued by MetLife and FED Blue, respectively. Below, we provide a chart with a summary of the benefits offered by these plans.

LARGEST FEDVIP DENTAL AND VISION PLAN OPTIONS, AS OF MARCH 31, 2012 *

Issuer name	Plan name	Additional information
MetLife (dental)	MetLife Federal Dental Plan—High	2012 Plan Benefit Brochure: http://www.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf .
BCBS Association (vision)	FEP BlueVision—High	2012 Plan Benefit Brochure: http://www.opm.gov/insure/health/planinfo/2012/brochures/FEPBlueVi.pdf .

Source: U.S. Office of Personnel Management.

* Please note that this information will be updated with the latest data when released.