Bernie Lowe & Associates, Inc.
"Beyond the Product"

Health Care Reform Update

IMPORTANT NOTICE REGARDING HEALTHCARE REFORM

Update #9 **February, 2013**

Final Regulations on Essential Health Benefits

The Department of Health and Human Services (HHS) has issued final regulations establishing the standards for Essential health benefits (EHB) that health insurers must offer starting in 2014. EHB apply to small group and individual markets both inside and outside the Exchanges. Self-insured employer plans, large group market insurers, and grandfathered plans are not subject to the EHB requirement. In addition, HHS, DOL and IRS have posted implementation FAQs that add additional comment to some of the positions in the final regulations and address issues on preventive health services. A link to the FAQ can be found on the last page of this update.

Highlights from the Final Regulations:

Essential Health Benefits

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, which is defined under section 1302(a) of the Affordable Care Act to include the coverage of EHB, application of cost-sharing limitations, and AV requirements.

The regulations provide that EHB's must be defined in a manner that reflects appropriate balance among the 10 statutory EHB categories, is not designed in such a way as to discriminate based on age, disability, or expected length of life, takes into account the health care needs of diverse segments of the population and does not allow denials of EHB based on age, life expectancy, or disability.

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 EHB categories:

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

The final regulations interpret "pediatric services" to mean services for individuals under the age of 19, however states have the flexibility to extend pediatric coverage beyond the 19-year age baseline. The regulations propose two options for states to supplement a base-benchmark plan that does not include pediatric oral or vision services. The first option is to supplement with the coverage included in the

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FEDVIP vision plan with the largest national enrollment offered to federal employees. The second option is to supplement coverage with the state's separate CHIP plan, if applicable.

Cost-Sharing Limits

The final regulations clarify issues raised in the proposed regulations about the applicability of cost-sharing limits on deductibles ($2,000 for self-only coverage and $4,000 for other coverage) and out-of-pocket maximums (while not yet set for 2014, the comparable limit for 2013 is $6,250 for self-only coverage). The agencies (HHS, DOL, and IRS) continue to interpret the deductible limit as applying only to employers and insurers in the small group market (and not to self-insured employer plans, large group employer plans, or large group market insurers). This was not included in the final regulations, however, HHS will accept further comment on the issue before issuing a final rule. The agencies agree that until such a final rule is issued, reliance on the agencies' interpretation is permitted.

With respect to out-of-pocket maximums (OOP), all non-grandfathered group health plans must comply with these limits. However, the agencies recognize that plans may utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. These processes will need to be coordinated, which may require new regular communications between service providers.

The agencies have determined that, only for the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the agencies will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

a. The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and

b. To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1).

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Clarifications on Mental Health Parity Requirement

In addition to repeating that mental health and substance use disorder benefits will be required a required EHB element, the final regulations restate that in order to satisfy the EHB requirements, mental health and substance use disorder benefits must comply with the federal mental health parity rules.

Minimum Value Rules

The final regulations define "actuarial value (AV)" as the percentage paid by a health plan of the total allowed costs of benefits. The "percentage of the total allowed costs of benefits" is further defined as the anticipated covered medical spending for EHB coverage 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. Importantly, the regulatory preamble announces that the MV calculator, with accompanying continuance tables, and the MV methodology are now available. In addition, the final regulations add a provision to reflect proposed preamble language that employer contributions to an HSA and amounts newly made available under integrated HRAs "that may be used only for cost sharing" may be taken into account in determining MV. According to the preamble, whether other types of integrated HRAs might count towards MV is being considered, and further guidance on the treatment of HRAs may be issued and the regulation amended as necessary.

As an alternative to using the MV Calculator, the final regulations proposes 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.

The final regulations generally adopt the prior proposed rules on minimum value (MV), which may have penalty consequences for large employers subject to the shared responsibility ("play or pay") rules starting in 2014.

Preventive Health Services

The FAQs address a number of additional issues raised by the separate requirement that non-grandfathered group health plans and health insurance coverage offered in group or individual markets provide certain preventive services (including contraceptive coverage) without imposing cost-sharing requirements. For example, if a plan or insurer doesn't have a provider in its network that can provide a particular preventive health service then it must cover the item or service when performed by an out-of-network provider without imposing cost-sharing.

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Additional information on 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) website: (http://cciio.cms.gov/resources/data/ehb.html).

FAQs about Affordable Care Act Implementation Part XII can be found at:
http://www.dol.gov/ebsa/faqs/faq-aca12.html

Final Regulations can be found at the following link:
http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf