Health Reform

Guidance on Mandated Coverage

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The Department of Health and Human Services issued regulations providing insight primarily into employer mandates with respect to small, insured, non-grandfathered plans and their interaction with the Exchanges, beginning in 2014. The regulations do, however, contain a few related items applicable to self-insured plans and large insured plans.

Background

Under the Affordable Care Act, effective for plan years beginning on or after January 1, 2014, small, insured, non-grandfathered group health plans and Exchanges must:

- Offer essential health benefits;
- Limit out-of-pocket cost sharing (tied to HSA qualified plan limits – maximum of $6,250 self-only/$12,500 family in 2013) ("cost-sharing limitation");
- Limit deductibles (cannot exceed $2,000/individual, $4,000/family) ("deductible limitation"); and
- Provide at least a bronze level of coverage.

It is important to note that, although there is no requirement that self-insured and large insured group health plans offer essential benefits, no plan can impose annual and lifetime dollar limits on any essential benefits that are covered.

What is Considered a Small Employer?

A "small employer" is an employer that employed an average of not more than 100 employees on business days during the preceding calendar year, and who employs at least one employee on the first day of the plan year. For plan years beginning before January 1, 2016, a state may elect to substitute "50" for "100."

What are Essential Health Benefits?

Essential health benefits have yet to be defined by regulations. For plan years beginning before the issuance of regulations defining essential health benefits, for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits." At a minimum, essential benefits will include items and services covered within the following 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
- Pediatric services, including oral and vision care

What is Included in Cost-Sharing?

Cost sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure which is a qualified medical expense with respect to essential benefits covered under the plan. Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

Proposed Regulations

Essential Health Benefits

The basic building block for an essential benefits package is a benchmark plan designated by each state (or by HHS, in the absence of state action) which is to be based on the largest insurance products sold in the state. The regulations propose that states select a benchmark plan from among several options identified in the proposed rule, and that all plans that cover essential benefits must offer benefits that are substantially equal to the benefits offered by the benchmark plan.

The benchmark plan options include: (1) the largest plan by enrollment in any of the three largest products in the state's small group market; (2) any of the largest three state employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the largest insured commercial HMO in the state. The regulations clarify that in the event a state does not make a selection, HHS will select as the default benchmark the largest small group product in the state, as described in option (1).

If a benchmark plan is missing any of the 10 statutory categories of benefits, the regulations have the state or HHS to supplement the benchmark plan in that category. The regulations also include a number of standards to protect consumers against discrimination and ensure that benchmark

plans offer a full array of essential benefits and services.

It remains unclear how this state-by-state approach applies to the restrictions on lifetime and annual limitations with respect to self-insured and multi-state plans. Further guidance is needed.

Cost-Sharing Limitation

The cost-sharing limitation appears on its face to apply to all non-grandfathered group plans and Exchange plans. HHS leaves some ambiguity as to whether it may apply only to small, insured, non-grandfathered plans and Exchange plans. Again, further guidance is needed.

Deductible Limitations

The proposed regulations confirm that the deductible limitations only apply to non-grandfathered plans and carriers in the small group market and do not apply to self-insured plans or health insurance carriers offering health insurance coverage in the large group market. The regulations propose that the permitted deductible levels may not be increased by amounts available under any health flexible spending account.

Bronze Level of Coverage

Actuarial value ("AV") is calculated as the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV of 70%, on average, a consumer would be responsible for 30% of the costs of all covered benefits.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain actuarial values, or metal levels (60% for a bronze plan, 70% for a silver plan, 80% for a gold plan, and 90% for a platinum plan). Additionally, carriers may offer catastrophic-only coverage with lower AV for individuals under age 30. To streamline and standardize the calculation of AV for health insurers, HHS is providing a publicly available AV calculator, which carriers would use to determine health plan AVs based on a national standard population. High deductible health plans are compatible with the AV calculator and small group market HDHPs offered with an HSA or HRA are considered to be integrated for these purposes.

To streamline and standardize the calculation of AV for health insurance issuers, HHS is providing a publicly available AV calculator, which issuers would use to determine health plan AVs based on a national, standard population. The proposed rule includes standards and considerations for plans with benefit designs that the AV calculator cannot easily accommodate. Consumer-driven health plans, such as high-deductible health plans and health savings accounts, are compatible with the AV calculator.

Since some plans will need flexibility to meet the metal levels, the proposed rule provides that a plan can meet a particular metal level if its AV is within 2 percentage points of the standard. For example, a silver plan may have an AV between 68 percent and 72 percent. In addition, the proposed rule provides flexibility for issuers in the small group market by permitting issuers to exceed annual deductible limits to achieve a particular metal level.

Minimum Value

Effective January 1, 2014, employers with 50 or more employees may pay a penalty when they either (1) do not offer coverage to their full-time employees and their dependents, or (2) offer coverage, but the coverage is not affordable or not of a minimum value and a full-time employee receives a subsidy to purchase coverage on the Exchange. The proposed regulations reiterate the methods of calculating minimum value related to the employer penalty. The three potential approaches are a minimum value calculator (not published yet), a safe harbor checklist, or an actuarial certification. Each of the approaches evaluates four categories of benefits: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services. HHS proposes to include any employer contributions to an HRA or HSA in the minimum value determination.