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HHS Releases First Round of Post-Election PPACA Guidance

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The Department of Health and Human Services (HHS) released the first guidance issued on the Patient Protection and Affordable Care Act (PPACA) since the 2012 presidential election. The new rules provide guidance on several key provisions of PPACA scheduled to become effective in 2014 involving essential health benefits (EHB), cost sharing limits, actuarial value, and other market reforms including new premium rating rules for insurance companies.

The new rules are in the form of proposed regulations and were published in the November 26, 2012 Federal Register. HHS has extended a 30-day comment period, during which interested parties can comment on the guidance and recommend changes favorable to their position.

In addition to these regulations, HHS, the Departments of Labor (DOL) and Treasury jointly released proposed rules implementing provisions under PPACA that expand rewards available under outcome-based wellness programs (i.e., wellness programs that provide a reward for satisfying a standard related to a health factor). Our alert on the wellness plan regulations can be found here: http://www.proskauer.com/publications/client-alert/new-guidance-on-wellness-programs-issued/.

Essential Health Benefits Package

Beginning with plan years starting in 2014, insurance companies that offer non-grandfathered health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package (EHB package), irrespective of whether such coverage is offered in an Affordable Insurance Exchange (Exchange). For these purposes, the small group market is defined to include employers with 1-100 employees. Until January 1, 2016, states may elect to limit the small group market to employers with 1-50 employees. Starting in 2017, states may permit large employers to purchase coverage for their employees through the small business health options program (SHOP) exchange.

The EHB package must include items and services in all of the following 10 categories, and be equal in scope to a typical employer-sponsored group health plan:

- 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.

As discussed below, these plans must offer a certain minimum level of financial protection given the plan's cost sharing mechanisms (e.g., deductible, coinsurance, copayments, and out-of-pocket limit), excluding premiums and out-of-network charges.

It is important to note that although large group health plans and self-funded group health plans are not required to offer the EHB package, sponsors of such plans should consider these regulations in the context of PPACA's prohibition on annual and lifetime dollar limits, which applies to all group health plans. For purposes of compliance with PPACA's annual and lifetime limit rules, the regulatory agencies will consider a large group or self-funded plan to have used a permissible definition of EHB if the definition is authorized by HHS (including any available benchmark option). Employers and plan sponsors of such plans should document their reasonable, good faith efforts to apply an authorized definition of EHB.

State Definition of EHB

Rather than opt for a national standard, HHS will require states to select one of the following benchmark plans, although the choice provide states significant flexibility to shape how EHB are defined:

- the largest plan in any of the three largest products in the state's small group market;
- any of the largest three state employee health benefit plans options;
- any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options; or
- the largest insured commercial HMO in the state.

Each state must select only one benchmark plan. 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. Although an applicable plan must provide benefits that are substantially equal to benefits offered by the state's chosen benchmark plan, the plan may substitute benefits as long as the benefit being substituted is actuarially equivalent to the benefit being replaced, is made within the same EHB category, and is not a prescription drug benefit.

The regulations also include standards to protect consumers against discrimination. Plans required to offer the EHB package are prohibiting from having plan designs that could discriminate against potential or current enrollees on the basis of age, expected length of life, present or predicted disability, degree or medical dependency, quality of life, or other health conditions.

Deductible and Cost Sharing Limits

The regulations contain an important clarification regarding the application of PPACA's annual deductible limits for small group plans. The regulations clarify that HHS, DOL and IRS interpret PPACA's deductible limits to apply only to individual and small group plans, and therefore they do not apply to large group or self-funded plans (provided that the large group plan is not offered through an Exchange).

Beginning with plan years starting in 2014, the annual deductible under non-grandfathered individual and small group plans cannot exceed $2,000 for single coverage or $4,000 for family coverage; however, a plan's deductible may exceed the annual limit if that plan may not reasonably reach the actuarial value of a given level of coverage without exceeding the limit. HHS may increase this amount in future years.

Further, total cost-sharing under such plans cannot exceed the annual out-of-pocket limit applicable to an HSA-qualified high deductible health plan. For 2013, that limit is $6,250 for single coverage, and $12,500 for family coverage. For these purposes, cost sharing excludes premiums, balance billing for out-of-network charges, and services not covered by the plan. Future guidance is expected to clarify the scope of this requirement (i.e., whether these limitations will apply to large group or self-funded plans as well).

Actuarial Value

Beginning with plan years starting in 2014, non-grandfathered individual and small group plans must have a minimum "actuarial value." Actuarial value is a way to express a health plan's overall level of financial protection in one number. For example, if a plan has an actuarial value of 70 percent, on average, a participant would be responsible for 30 percent of the costs of all covered benefits. Actuarial value is not based on a plan's claims experience; rather, the calculations to determine actuarial value are performed on an average basis for a given population. For example, assume two individuals are enrolled in a health plan with a 70 percent actuarial value. One individual rarely goes to the doctor. The other has a number of high-cost procedures during the year. The individual who rarely sees a doctor will likely be responsible for more than 30 percent of the cost of his care if he were to see a doctor, perhaps because he will not have satisfied the plan's deductible (and will therefore be responsible for 100 percent of the cost of his care until the deductible is satisfied). On the other hand, the individual who has a number of high-cost procedures during the year may be responsible for less than 30 percent of the cost of his care, because he may reach the plan's out-of-pocket limit.

In the Exchanges, actuarial value is represented as metal levels: 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. In addition, insurers may offer catastrophic-only coverage ("tin" plans) with lower actuarial levels for eligible individuals (adults under age 30 and people who otherwise have unaffordable coverage). A 2 percent margin of error is permitted (e.g., a silver plan may have an actuarial value between 68 percent and 72 percent).

These metal levels are intended to help consumers compare plans with similar levels of coverage and make informed decisions about their health plans.

Health Insurance Market Rules and Rate Reviews

In 2014, additional market reforms under PPACA come into effect. The proposed regulations permit health insurers in the individual and small group markets to vary premiums based only on age (within a 3:1 ratio for adults), tobacco use (within a 1.5:1 ratio and subject to wellness program requirements in the small group market), family size, and geography. All other factors – such as preexisting conditions, health status, claims history, duration of coverage, gender, occupation, and small employer size and industry – will no longer be included for premium rating purposes. However, an insurer may restrict enrollment in health insurance coverage to open or special enrollment periods.

These rules apply to large employers who purchase coverage through a SHOP exchange, if the state expands eligibility to large employers in 2017.

Under the proposed rule, health insurers are required to maintain a single statewide risk pool for each of their individual and small employer markets (not including grandfathered health plans), unless a state chooses to merge the individual and small group pools into one pool. Premiums and annual rate changes would be based on the health risk of the entire pool. This provision prevents insurers from using separate insurance pools within markets to circumvent the market reforms and to charge people with greater health problems higher premiums by increasing their premiums at higher rates than other, healthier risk pools.

The rules reaffirm existing protections that individuals and employers have with respect to coverage renewal. For example, these protections would prohibit insurers from refusing to renew coverage because an individual or employee becomes sick or has a preexisting condition. Additional rules are expected that will prohibit preexisting condition limitations or exclusions for all group health plans starting in 2014, regardless of grandfathered status and whether the plan is insured or self-funded.

The rule also includes provisions for enrollment in catastrophic plans. Catastrophic plans have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing. They provide coverage of the essential benefits once the annual limitation on cost sharing is reached, but do not provide a bronze, silver, gold or platinum level of coverage. They cover at least three primary care visits per year before reaching the deductible, and may not impose any cost-sharing requirements for preventive services.

Lastly, the regulations provide that if any health insurance product is subject to a rate increase, the insurer must justify the increase to the Centers for Medicare & Medicaid Services (CMS). An insurer must justify all rate increases that are filed in a state on or after April 1, 2013, or are effective on or after January 1, 2014 in a state that does not require the rate increase to be filed.

Proskauer is committed to monitoring developments and providing its clients with the latest, up-to-date information on new developments under PPACA. Please contact your Proskauer lawyer for answers to your questions on health care reform.

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