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Kaminsky & Associates, Inc.

**The following is a summary of proposed regulations.
Some or all of the provisions may change when final rules are issued.**

HIGHLIGHTS OF PROPOSED RULES ON ESSENTIAL HEALTH BENEFITS AND ACTUARIAL VALUE

On Nov. 20, 2012, the Department of Health and Human Services (HHS) issued a proposed rule that addresses a number of questions surrounding essential health benefits and determining actuarial and minimum value. This rule is still in the "proposed" stage, which means that there may -- and likely will -- be changes when the final rules are issued.

Provisions that Particularly Affect Insured Small Employers

Beginning in 2014, nongrandfathered insurance coverage in the individual and small group markets will be required to provide coverage for "essential health benefits" (EHBs) at certain levels of coverage. The proposed rule:

- Confirms that these policies, whether provided through or outside of an exchange, will be required to:
    - cover the 10 essential health benefits:
        - ambulatory/outpatient
        - emergency
        - hospitalization
        - maternity and newborn care
        - mental health and substance use

        - prescription drugs
        - rehabilitative and habilitative services and devices - e.g., speech, physical and occupational therapy
        - laboratory services
        - preventive and wellness services and chronic disease management
        - pediatric services, including pediatric dental and vision care
    - provide coverage that meets the "metal" standards (an actuarial value of 60, 70, 80 or 90 percent; actuarial value means the percentage of allowed costs the plan is expected to pay for a standard population)
    - meet cost-sharing requirements (in most instances, the deductible for in-network services could not exceed $2,000 per person or $4,000 per family, and the out-of-pocket limit for in-network services could not exceed the high deductible health plan limit for health savings account eligibility, which is currently $6,050 per person or $12,100 per family)

- Confirms that each state would choose its own EHB package, based on a "base-benchmark" plan already available in the state. Many states have already chosen their base-benchmark plan; those who have not done so have until Dec. 26, 2012, to make their selection or the federal government will make the selection for them. Information on state elections to date and the policy that will apply if no choice is made is here: Additional Information on Proposed State Essential Health Benefits Benchmark Plans | cciio.cms.gov
- Provides a way to cover any gaps in EHB coverage under the base-benchmark plan (because many plans do not currently cover habilitative care or pediatric vision / dental services)
- Provides that other policies in the exchange and small-group market must generally provide the same coverage within each EHB category as the base-benchmark plan, but that they may substitute an actuarially equivalent benefit within a category
- States that HHS will provide a calculator that must be used in most situations to determine actuarial value
- Provides that a plan that is within 2 percent of the metal standard would be acceptable (for instance, a plan with an actuarial value of 68 percent to 72 percent would be considered a "silver" plan)
- Provides that state mandates in place as of Dec. 31, 2011, would be considered EHBs
- Provides that current year employer contributions to a health savings account (HSA) or a health reimbursement arrangement (HRA) would be considered as part of the actuarial value calculation

Provisions that Particularly Affect Self-Funded and Large Employers

For the most part, self-funded and large-group plans would not be required to provide coverage for each of the 10 EHB categories. However, these plans would not be allowed to impose annual dollar limits on EHBs. Also, although self-funded and large-group plans would not be required to cover all of the EHBs, they would be required to provide coverage for all of the "core" benefits -- hospital and emergency care, physician and mid-level practitioner care, pharmacy, and laboratory and imaging - to be considered a plan that provides "minimum value."

The proposed rule also:

- States that HHS and the IRS would provide a minimum value calculator and safe harbor plan designs that self-funded and large-group plans could use to determine whether the plan provides minimum value (the safe harbor plan designs were not included in the proposed rule)
- Provides that current-year employer contributions to an HSA or a HRA would be considered as part of the minimum value calculation
- Resolves an ambiguity in the law and provides that the restrictions on maximum deductibles would **not** apply to self-funded and large-employer plans.

The proposed rule may be found here: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Important: This rule is still in the "proposed" stage, which means that there may be changes when the final rule is issued. The public may make suggestions until Dec. 26, 2012, on how the proposed rule should be changed before it is finalized. Employers should view the proposed rule as an indication of how plans will be regulated beginning in 2014, but need to understand that changes are entirely possible.

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Kaminsky & Associates, Inc.

Kaminsky & Associates, Inc. I www.teamkaminsky.com I Ph: (419) 535-5502