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Kaminsky & Associates, Inc.

AGENCIES ISSUE FINAL REGULATIONS, OTHER GUIDANCE THAT AFFECT INSURED PLANS

Whistleblowing | Preventive Care | Out-of-Pocket Limits | Essential Health Benefits & Actuarial Value | Health Insurance Market Reforms

Late last week the Department of Health and Human Services (HHS) and the Department of Labor (DOL) issued several more regulations on the Patient Protection and Affordable Care Act (PPACA). Some of the new rules affect all plans, while others only affect plans based on their size.

Unfortunately, it is still unclear what size makes a plan "large" or "small" under the benefits rules. Clearly, a plan with fewer than 50 participants is "small" and a plan with over 100 participants is "large." States have the option to consider plans below 100 as "small" until 2016, but it is not clear yet how they make that choice. It is also still not clear how employees/participants will be counted for this purpose, although part-time employees are expected to be counted as "full-time equivalent" employees in the same way they are for the play or pay penalty.

Whistleblowing/Prohibiting Retaliation

Impacts all fully insured plans beginning April 2013

PPACA prohibits employers (including insurers) from retaliating against an employee for reporting possible violations of PPACA to his employer or to the government, providing testimony about the possible violation or refusing to violate the law. It also prohibits retaliating or taking an unfavorable employment action against an employee because he or she received a premium tax credit. Unfavorable employment actions include firing or laying off, denying benefits, reducing pay or hours, denying overtime or promotion and making threats.

The government has now issued procedures that will be followed if an employee believes he or she has been retaliated against. The employee must file a complaint within 180 days after the claimed retaliation occurred. Complaints will be filed with and investigated by the Occupational Safety and Health Administration. (OSHA handles most whistleblowing complaints made with the Department of Labor.) If

the complaint is found to be valid, the employer could be required to reinstate the employee, pay back wages, restore benefits, etc.

Preventive Care

Impacts all nongrandfathered fully insured plans now

The agencies have received many questions about the requirement to provide first-dollar preventive care. They have now issued a FAQ that clarifies that:

- While plans generally do not need to provide out-of-network preventive care if there are no in-network providers able to provide the needed preventive care service, out-of-network care must be provided at no cost
- Preventive over-the-counter drugs, such as aspirin for those at risk for heart attacks, must be covered at 100 percent only if the over-the-counter drug is actually prescribed
- Routine immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) must be covered without cost-sharing beginning with the plan year that begins one year after the recommendation is adopted by the Centers for Disease Control and Prevention (CDC)
- When a screening or immunization recommendation applies only to those who are "high risk," the attending provider is the one who determines if the person is high risk
- If a polyp is removed during a screening colonoscopy, the entire procedure must be covered without cost-sharing, as a preventive service
- The BRAC test itself, as well as genetic testing, must be covered at 100 percent if the attending provider determines the woman is at high risk for the BRAC mutation based on family history
- Required contraceptive coverage does not include male contraceptives
- Plans may not limit coverage to oral contraceptives and must cover IUDs, implants, sterilization, device removal, etc. Plans may impose reasonable management techniques, such as limiting first dollar coverage to generics unless use of the generic would be medically inappropriate for the individual. Over-the-counter contraceptives must be covered only if they are FDA-approved and prescribed by the woman's health care provider
- Annual HIV testing and triennial HPV DNA testing must be covered as part of well-woman care

Out-of-Pocket Limits

Impacts all nongrandfathered fully insured plans beginning with the 2014 plan year

The FAQ also talks about the out-of-pocket maximum requirements. Beginning with the 2014 plan year, plans may not have an out-of-pocket maximum that is larger than the allowed out-of-pocket limit for high-deductible health plans (HDHP) issued in connection with a health savings account. (The out-of-pocket limit includes the deductible, coinsurance and copays. For 2013, the HDHP out-of-pocket limit is $6,250 per person and $12,500 per family.)

The FAQ provides one year of transition assistance to plans that have separate major medical and prescription drug vendors. For the 2014 plan year only, those plans may apply the out-of-pocket limit separately to the major medical and prescription drug parts of coverage. Similar flexibility will not be available to plans with separate mental and nervous benefits, as the Mental Health Parity Act does not allow separate mental and nervous benefit limits.

Minimum Value

Impacts large fully insured plans with 50 or more employees

Large group insured plans are not required to provide the ten "essential health benefits" or coverage at a "metal level" as small plans will be required to do. (The essential health benefits are coverage within these categories - 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, and pediatric services, including pediatric dental and vision care. Under the "metal level" requirements, a plan must be designed to cover 90 percent of covered costs - a "platinum" plan, 80 percent of covered costs - a "gold" plan, 70 percent of covered costs - a "silver" plan or 60 percent of covered costs - a "bronze" plan).

However, large plans cannot impose lifetime or annual limits on essential health benefits and to avoid the employer-shared responsibility/play or pay penalty they must provide minimum value (an actuarial value of at least 60 percent). A proposed minimum value calculator has been released; it is at: Regulations and Guidance | cciio.cms.gov

Current year employer contributions to health reimbursement arrangements and health savings accounts are included in the minimum value calculation.

The agencies had said they planned to provide safe harbor minimum value plan designs, but there is still no time table for issuing those plan designs.

Essential Health Benefits and Actuarial Value

Impacts nongrandfathered small-group plans (both in and outside the exchange) beginning with the 2014 plan year

Beginning with the 2014 plan year all nongrandfathered plans in the small group market – whether inside or outside the exchange - will need to provide the "essential health benefits package" (EHB package). The EHB package includes coverage for the 10 essential health benefits, at the metal levels, with permitted cost-sharing. The essential health benefits are coverage within these categories - 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, and pediatric services, including pediatric dental and vision care.

Each state will have its own benchmark plan, supplemented as needed to provide acceptable coverage in all 10 categories. The chosen benchmark plan will remain the benchmark for 2014 and 2015. (The selected benchmark plans are listed beginning on page 141 of the final Essential Health Benefits regulation; the link is at the end of this update.) Carriers may substitute an actuarially equivalent benefit within each category. Abortion services, including pharmaceuticals, do not need to be covered by any plan.

Small group plans, both in and outside the exchange, may only provide coverage at the metal levels. (A plan that is designed to cover 90 percent of covered costs is a platinum plan, a plan designed to cover

80 percent of covered costs is a gold plan, a 70 percent plan is a silver plan and a 60 percent plan is a bronze plan.) There will be a permitted variation of 2 percent so, for example, a silver plan would have an actuarial value of 68 to 72 percent. In addition, catastrophic plans may be offered both in and out of the exchanges to individuals aged 21 to 30 and to those who can prove financial hardship. The catastrophic plans must provide three first-dollar primary care visits per year, first dollar preventive coverage and coverage for the essential health benefits once the deductible (which must be at least $6,250 single and $12,500 family, indexed) is reached.

Cost-sharing (which will be based on in-network usage) will be limited to a deductible of $2,000 per person and $4,000 per family. However, bronze plans will be allowed to increase the deductible where necessary to meet actuarial value requirements (additional details on how this may be done will be provided). The out-of-pocket limit is the maximum out-of-pocket limit that may be in a high deductible health plan linked to a health savings account (currently $6,250 single and $12,500 family).

Current year employer contributions to health reimbursement arrangements and health savings accounts are included in the actuarial value calculation. It does not appear they can be combined with the plan deductible to meet the $2,000/$4,000 limit.

The actuarial value calculator for small group plans has been finalized and is at: Regulations and Guidance | cciio.cms.gov

Market Reforms – Guaranteed Access

Impacts all nongrandfathered fully insured plans, whether inside or outside the exchange, beginning with the 2014 plan year

Guaranteed issue and renewal will apply to all insured plans regardless of size. Participation and employer contribution requirements will not be permitted under the guaranteed availability rules, although insurers may impose participation and employer contribution requirements at renewal. To ease the risk of anti-selection insurers may limit small groups that don't meet participation or employer contribution requirements to an annual open enrollment period, from Nov. 15 to Dec. 15 each year. Additional strategies to combat anti-selection are being considered. A 30-day special enrollment period will be available both in and out of the exchange following COBRA qualifying events and a similar 30-day "limited open enrollment period" will be available if a person loses minimum essential coverage, becomes eligible or ineligible for premium tax credits/subsidies or moves out of the service area.

Market Reforms – Fair Health Insurance Premiums

Impacts all nongrandfathered fully insured small group plans (both in and outside the exchange) beginning with the 2014 plan year

The changes in the rules that apply to fully insured small groups, whether the coverage is provided inside or outside the exchange, are significant. From an employer standpoint, the most significant change probably is that premiums may only be based on four factors – age (with a maximum surcharge of 300 percent for the oldest members), tobacco use (with a maximum surcharge of 150 percent for tobacco users), family status and geography. Gender and health status will no longer be a permitted factor. States also may limit or prohibit the age and/or tobacco surcharge.

Premium age bands will be in one-year increments, except for ages 0 through 20 and 64 and older. The member's age on the renewal date (or entry date if a new member) will apply for the full year. Unless the state prohibits the age and tobacco surcharge, each family member must be rated individually, with their costs then aggregated. (If a family has more than three children, only the premiums of the three oldest children who are under age 21 will be considered.)

Insurers in the small group market must calculate per member rates, although states may require and/or employers may elect to use composite rates.

Tobacco use is defined as using any tobacco product an average of four or more times per week within the prior six (or fewer) months. Small group plans must offer smoking cessation wellness programs to provide a way to offset the surcharge. Insurers may not rescind coverage based on a misrepresentation of non-use of tobacco, but they can collect back premiums.

The text of the FAQs on out-of-pocket limits and preventive services is here:
FAQs About Affordable Care Act Implementation Part XII

The text of the interim final rule on PPACA whistleblowing and retaliation is here:
http://www.dol.gov/find/20130222/OSHA2013.pdf

The text of the final rule on essential health benefits is here:
http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf

The text of the final rule on health insurance market reforms is here:
http://www.ofr.gov/OFRUpload/OFRData/2013-04335_PI.pdf

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Kaminsky & Associates, Inc.

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