PPACA Compliance Reminders for 2013 and New PPACA Guidance on Essential Health Benefits and Wellness Programs

New Requirements for 2013 As reported in our Summer issue of the Health Care Quarterly, group health plans will be subject to the following new requirements in 2013: • *Preventive services.* New guidelines for women's preventive services were published on August 1, 2011. Non-grandfathered group health plans must cover the newly recommended services effective with the first plan year beginning on or after August 1, 2012. • *Summary of Benefits and Coverage.* Effective with the first plan year beginning after September 23, 2012, a plan must provide participants with a Summary of Benefits and Coverage (SBC). The SBC summarizes key provisions of the plan and presents the information in a standardized form designated by HHS. Plans subject to ERISA must provide the SBC in addition to the plan's Summary Plan Description (SPD). However, the SBC may be provided as a stand-alone document or in combination with other summary materials, including the SPD. **Essential Health Benefits and Wellness Programs** The Department of Health and Human Services (HHS) recently issued two new sets of proposed regulations under the Patient Protection and Affordable Care Act (PPACA) that relate to group health plans. The first set provides guidance on the scope and determination of "essential health benefits" and the definition of "minimum value." The second set amends existing regulations that prohibit nondiscrimination in wellness programs. **The Essential Health Benefits Package** Effective for plan years that begin on or after January 1, 2014, non-grandfathered, fully insured plans in the small group market must provide an "essential health benefits package." (A plan is in the small group market if the employer that sponsors the plan employed 100 or fewer employees in the prior year.) An essential health benefits package includes coverage of items and services within ten "essential health benefits" categories and specific limits on cost-sharing requirements. **Essential Health Benefits** Essential health benefits (EHBs) are benefits that provide coverage of the following ten service categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. On December 16, 2011, an HHS bulletin announced that HHS intends to let each State define EHBs by selecting a benchmark plan from a list of plans HHS believes best reflect a typical employer plan. The proposed regulations follow the approach outlined in the HHS bulletin. Each state may identify an EHB-benchmark plan from the following: (a) the largest health plan by enrollment in any of the three largest small group insurance products in the state's small group market; (b) any of the three largest employee health benefit plan options by enrollment offered to State employees in the State; (c) any of the three largest national Federal Employees Health Benefits Program plan options by aggregate enrollment; or (d) the coverage plan with the largest insured commercial non-Medicaid enrollment offered by an HMO in the State. If the selected EHB-benchmark plan does not include items or services within one or more of the ten required categories, the plan must be supplemented by adding the category of benefits offered under a different benchmark plan or as directed in the proposed regulations. The proposed regulations clarify that a plan need not offer benefits that are identical to the benefits of the EHB-benchmark plan, but must provide benefits that are "substantially equal" to the EHB-benchmark plan, including covered benefits and limitations on coverage (such as benefit amount, duration, and scope). The plan also must provide coverage of preventive services as required by PPACA, even if the EHB-benchmark plan is a grandfathered plan exempt from the requirement to cover preventive services. The Kansas Commissioner of Insurance has recommended to the Governor that Kansas select as its benchmark

plan the Blue Cross Blue Shield of Kansas Comprehensive Plan, which is the largest small group plan by enrollment. This plan would be supplemented by adopting the pediatric oral and vision benefits of the Kansas Children's Health Insurance Program (CHIP). Missouri has not yet selected a benchmark plan. HHS designated a default plan in the event any State does not choose a benchmark plan. The default plan for Missouri is the Healthy Alliance Life Insurance Co. (Anthem BCBS) Blue 5 Blue Access PPO, Medical Option 4, Rx Option D, supplemented by the Federal Employees Dental Vision Insurance Program benefits for pediatric oral and vision benefits. It is important to note that even though self-insured plans and insured plans in the large group market are not required to cover EHBs, these plans may need to define EHBs for a different PPACA requirement. A group health plan may not impose a lifetime limit on the dollar amount of EHBs for any individual, and annual dollar limits on EHBs will be fully phased out by January 1, 2014. However, a group health plan may set lifetime or annual limits on benefits that are not EHBs. Therefore, a plan that imposes lifetime or annual limits on non-EHBs must include a definition of EHBs that is consistent with the benchmark plan selected by the applicable State. **Cost-Sharing Requirements** PPACA provides that a plan's cost-sharing requirements, which include deductibles, co-payments, co-insurance, and other similar charges, cannot exceed an amount equal to the maximum deductible amount permitted for a "high deductible health plan" as defined by the Internal Revenue Code in 2014. (The current amounts under the Code are $6,050 for self-only coverage and $12,100 for other coverage.) Additionally, annual deductibles for plans in the small group market generally cannot exceed $4,000 (or $2,000 for a plan that covers a single individual). After 2014, these amounts will be subject to an annual increase by HHS. The question unanswered by the proposed regulations, however, is which plans will be required to comply with these requirements. HHS specifically reserved a section of the regulations for future rules that will implement the cost-sharing requirements. But in the preamble to the regulations, HHS stated that it interprets the cost-sharing provisions to apply only to plans that must offer an essential health benefits package. In other words, future HHS guidance may clarify that the cost-sharing requirements apply only to insured small group market plans, and not to self-insured or insured large group market plans. **Minimum Value** As reported in our Fall issue of the Health Care Quarterly, effective January 1, 2014 certain large employers may be penalized under the PPACA shared responsibility provisions if they fail to offer full-time employees and their dependents the opportunity to enroll in a health plan that provides minimum essential coverage. A required component of minimum essential coverage is that the health plan provides "minimum value." A plan provides minimum value if it covers at least 60% of the total allowed costs of benefits provided under the plan. The proposed regulations provide that a group health plan may use one of three methods to determine that it provides minimum value: 1. The minimum value calculator that will be made available by HHS; 2. A safe harbor established by HHS; or 3. A certification by an actuary, if neither of the above methods is appropriate. HHS will most likely provide additional guidance when it rolls out the minimum value calculator and in the event it issues a minimum value safe harbor. **Wellness Programs** Under current law, the nondiscrimination rules for an employer's wellness program vary depending on whether the program requires participants to meet a certain health standard to receive a reward. For example, a wellness program could provide that if a participant maintains a cholesterol count under 200, the participant will receive a 10% discount on premiums for coverage under the employer's group health plan. This type of program, now known as a health-contingent program, conditions the receipt of a reward (the discounted premium) on satisfaction of a specific health standard (cholesterol under 200). A wellness program that is not health-contingent meets the nondiscrimination rules if the employer offers participation in the program to all similarly situated individuals. To determine which employees are "similarly situated," an employer may group employees based on a bona fide employment-based classification consistent with the employer's usual business practices. For example, depending on all the facts and circumstances of the particular situation, it may be permissible for an employer with offices in multiple cities to offer a wellness program to employees in one city but not others. A health-contingent wellness must currently limit the amount of the award to 20% of the cost of employee-only coverage under the group health plan. Additionally, the program must offer a reasonable alternative health standard to any individual for whom it is unreasonably difficult to achieve, or medically inadvisable to

achieve or attempt to achieve, the normal standard. All materials that describe the terms of the program must disclose the availability of the alternative standard. The most significant change made by PPACA and the proposed regulations affects health-contingent programs. Effective January 1, 2014, the 20% limit on rewards will increase to 30%. Additionally, the regulations propose to raise the 20% limit to 50% for wellness programs designed to prevent or reduce tobacco use. Aside from these limit increases, the proposed regulations mainly reiterate the requirements of the current regulations with some minor clarifications. With respect to alternative health standards for health-contingent programs, the regulations clarify that plans need not establish an alternative standard until an individual requests one, and plans may waive the applicable health standard instead of providing an alternative standard. The regulations also provide more specific requirements for certain types of alternative standards. For example, if the alternative standard is completion of an educational program, the plan must make the program available and pay for the program's cost, as opposed to requiring the employee to find and pay for an educational program unassisted. The proposed regulations also include improved sample language that a plan may use to disclose the availability of an alternative standard. As PPACA continues to unfold through regulations and other guidance, please do not hesitate to contact us if you have questions about the impact of PPACA to your group health plan or your employees.