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EMPLOYEE BENEFITS UPDATE

Most Health Plans Subject to Annual Out-of-Pocket Maximum and HHS Final Regulations on Essential Health Benefits Offered in Individual and Small Group Markets

This update first discusses the annual limitations on the amounts group health plans may require participants to pay for deductibles, co-insurance, co-payments and other expenditures ("cost-sharing") for essential health benefits for plan years beginning on or after January 1, 2014. These limitations do not apply to health plans that were in existence on the date the Patient Protection and Affordable Care Act (the "Act") was enacted (March 23, 2010) if they have not been significantly changed ("grandfathered plans").[1] Separately, this update discusses recently published final regulations regarding the essential health benefit packages that must be offered by insurers in the individual and small group markets.[2]

Annual Out-of-Pocket Maximum and Annual Deductible

The Act requires all nongrandfathered group health plans, both insured and self-insured, to limit cost-sharing on essential health benefits to the same out-of-pocket maximums that apply to high deductible health plans. The limits imposed by the Act apply for plan years beginning on and after January 1, 2014. Although the limits for 2014 have not yet been announced, in 2013 the out-of-pocket maximums that apply to high deductible health plans are $6,250 for self-only coverage and $12,500 for family coverage.

The Department of Health and Human Services ("HHS"), the Treasury Department and the Department of Labor (the "Departments") have recognized that group health plans often have multiple service providers (such as one third-party administrator for major medical coverage, and a separate pharmacy benefit manager and a separate managed behavioral health organization) that may impose different levels of out-of-pocket maximums and may have different methods for crediting employees' health expenses against the out-of-pocket maximums.[3] The Departments have clarified that new statutory annual out-of-pocket maximums discussed in the previous paragraph apply in the aggregate to all service providers. As a result, all service providers for a plan will need to coordinate their benefit design planning so that the

[1] Interim final regulations published in the Federal Register on June 17, 2010 address the types of changes to a plan that would cause it to lose its grandfathered status. See our Employee Benefits Update dated August 4, 2010 for information on grandfathered plan status.

[2] The term "small group market" refers to health insurance coverage offered to employers that employed, on average, no more than 100 employees in the prior year and employ at least one employee in the current year.

[3] FAQs About Affordable Care Act Implementation (Part XII), Feb. 20, 2013.

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plan does not exceed the statutory out-of-pocket maximums. However, the Departments announced that for the 2014 plan year only, the statutory out-of-pocket maximums will be relaxed when a plan has multiple service providers if the following two conditions are satisfied: (i) the plan's major medical coverage (including mental health and substance use disorder benefits) complies with the out-of-pocket maximums and (ii) the out-of-pocket maximums that apply to each other type of plan coverage, e.g., prescription drug coverage, separately satisfy the out-of-pocket maximums. For example, if a plan is comprised of a self-insured major medical component administered by one third-party administrator and a prescription drug component administered by a separate pharmacy benefits manager, in 2014 the annual out-of-pocket maximum may apply separately to each component.

The Act provides that in addition to the overall statutory annual out-of-pocket maximums there are separate limits on the maximum annual deductibles that plans may impose (the "Separate Deductible Limit") for plan years beginning on and after January 1, 2014: $2,000 for self-only coverage and $4,000 for family coverage. The preamble to the final regulations published by HHS in the Federal Register on February 25, 2013 regarding essential health benefit packages points out that the Separate Deductible Limit provision in the Act cross-references another provision of the Act that actually sets forth the maximum dollar amounts for annual deductibles and that provision applies only to nongrandfathered plans and issuers in the individual and small group market. The preamble states that the Departments read these two provisions together to mean that the Separate Deductible Limit applies only to nongrandfathered plans and issuers in the individual and small group market. The Departments intend to publish regulations in the future consistent with this interpretation. In the interim, the Departments have stated in a set of frequently asked questions[4] that until such regulations become effective, group health plans can rely on the Departments' stated intention to apply the Separate Deductible Limit only to nongrandfathered plans and issuers in the small group market. The frequently asked questions are silent as to whether the Separate Deductible Limit will apply in the individual market.

Next Steps for Employers

An employer that has multiple third-party administrators will need to examine the annual out-of-pocket maximums imposed by each third-party administrator to determine whether the employer's group health plan will satisfy the out-of-pocket maximum in 2015. In many cases, this will require coordination among the employer and all third-party administrators.

Essential Health Benefits Offered in Individual and Small Group Markets

Final regulations recently published by HHS direct health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market to ensure that the coverage includes an "essential health benefit ('EHB') package." Large group health plans, both insured and self-insured, are not required to comply with the EHB package requirements. However, because all group health plans, including grandfathered plans and self-insured plans, must not have any annual limit on essential health benefits for plan years beginning on and after January 1, 2014, it is important for all employers sponsoring group health plans to know what benefits are considered essential health benefits. [5]

There are three components of an EHB package: (i) it must offer coverage for essential health benefits, (ii) there must be an annual limit on cost sharing consistent with the final regulations and (iii) coverage must include one of four plan designs, referred to as a bronze plan, silver plan, gold plan or platinum plan.[6] These plans differ in the percentage of

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[4] FAQs About Affordable Care Act Implementation (Part XII), Feb. 20, 2013.

[5] In addition, understanding what are essential health benefits will likely be important in determining whether a group health plan, including a large or self-insured plan, offers the "minimum essential coverage" necessary to avoid excise taxes. See our Employee Benefits Update dated January 10, 2013.

[6] In addition, catastrophic coverage is available to certain individuals younger than age 30.

the anticipated health benefits they will pay. See discussion under the heading "Bronze, Silver, Gold and Platinum Levels" below for more information regarding these plans.

EHB packages must be offered in the individual and small group markets, whether the insurance coverage is available inside or outside a state exchange, a federally facilitated exchange or a state partnership exchange (together referred to as an "Exchange"). The EHB package requirements for the small group market apply for plan years beginning on or after January 1, 2014 and for the individual market for policy years beginning on or after such date. Each of these three components is summarized below.

Essential Health Benefits

The Act directs HHS to define essential health benefits, which must include items and services within the following 10 benefit 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, and
- pediatric services, including oral and vision care.

The scope of EHBs is to be equal to the scope of benefits provided under a "typical" employer plan. The Act does not define what is considered a typical employer plan.

HHS previously announced that EHBs are to be defined by a benchmark plan selected by each state reflecting both the scope of services and any limits offered by a typical employer plan in that state. For 2014 and 2015, the regulations allow a state to choose among four benchmark plan types.[7] If a state does not designate a benchmark plan, HHS will select a default benchmark plan for that state that is the largest plan by enrollment in the largest product in the state's small group market. HHS based its decision to focus on the small group market after reviewing information gathered from large and small employer plans and plans offered to public employees. The regulations do not address which state's benchmark plan applies when an employer in a small group market has operations in more than one state.

Cost-Sharing Limits

The amount an insurer may require individuals in the individual or small group market to pay in the form of cost-sharing is limited to the maximum annual deduction allowed for contributions to a health savings account (for 2013, $6,250 for self-only coverage and $12,500 for family coverage). These cost-sharing limits do not apply to premiums, non-covered services, and balance billing charged by an out-of-network provider.

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[7] The four benchmark plan types are: (i) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; (ii) any of the largest three state employee health benefit plans by enrollment; (iii) any of the largest three Federal Employees Health Benefits Program options by enrollment; or (iv) the largest insured commercial non-Medicaid health maintenance organization ("HMO") operating in the state.

Bronze, Silver, Gold and Platinum Levels

The Act requires health insurance plans offered on an Exchange or in the individual or small group market to satisfy certain specified levels of coverage. As previously stated, there are four levels of coverage, i.e., bronze, silver, gold and platinum plans. By establishing four standard levels of actuarial value, the federal government expects that consumers will be able to compare plans with different cost-sharing designs and better understand their relative values. The coverage level for each type of plan is based upon the actuarial value of the expected health care costs the plan will cover. The actuarial value is calculated by computing the ratio of (i) the total expected payments by the plan for EHBs (taking into all cost-sharing) for individuals in a standard population over (ii) the total costs of EHBs that individuals in a standard population are expected to occur.[8] For example, a bronze plan, which has an actuarial value of 60% would be expected to pay, on average, 60% of the medical expenses for EHBs expected to be incurred by individuals in a standard population, and the individuals covered by the bronze plan would be expected to pay, on average, 40% of such expected expenses in the form of deductibles and other cost-sharing.[9] Annual employer contributions to health savings accounts and employer contributions to health reimbursement accounts that are integral to a group health plan are taken into account in determining the actuarial value of the plan. The regulations permit a variance in the percentages of actuarial value of two percentage points, either plus or minus.

An issuer must use a calculator developed by HHS to determine whether the level of coverage it offers is bronze, silver, gold or platinum. The calculator was developed using claims data weighted to reflect the standard population projected to exist in the individual and small group market, and data will be updated and the calculation adjusted for each enrollment year. However, if the design of the plan or policy does not permit the calculator to provide an accurate summary of the value of the plan, the insurer may submit an actuarial certification that the methodology for valuing the benefits available under the plan falls within the parameters of the calculator's actuarial valuation.

Next Steps for Employers

Employers should review their group health plans to determine if there are any annual limits on benefits. If so, employers will need to determine whether such a benefit is an essential health benefit, because no annual limits (or lifetime limits) on essential health benefits are permitted for plan years beginning on and after January 1, 2014.

If you have any questions regarding this update, please contact the Sidley lawyer with whom you usually work.

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[8] "Actuarial Value and Cost-Sharing Reductions Bulletin," Feb. 24, 2012. Available at: http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

[9] The actuarial value of a silver plan is 70%, a gold plan, 80% and a platinum plan, 90%.