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# Administration Releases Proposed Rules on Essential Health Benefits, Insurance Market Reforms Under Health Care Law

The Department of Health and Human Services (“HHS”) today (November 20, 2012) released a proposed rule addressing the definition of essential health benefits (“EHBs”) and the determination of actuarial value in the individual and small group markets. Notably for large group plans, the proposed rule also provides some additional insight into the determination of whether plans meet the law’s minimum value standard. HHS also released a proposed rule on health insurance market reforms (including guaranteed issue requirements and application of new limits on premium rate bands); and the Internal Revenue Service (“IRS”), the Department of Labor’s Employee Benefits Security Administration (“EBSA”) and HHS’ Centers for Medicare and Medicaid Services (“CMS”) together issued a notice of proposed rulemaking on wellness programs in group health plans.

Comments on the proposed rules on EHBs and insurance market reforms are due by December 20, 2012. Comments on the notice of proposed rulemaking on wellness programs are due 60 days from its November 26, 2012, publication in the Federal Register.

Key provisions of the proposed rules and notice of proposed rulemaking are highlighted below.

### **Minimum value, actuarial value**

Of note to large employers, the proposed rule on EHBs re-affirms the general approach states in previous guidance (Treasury Notice 2012-31) to determining minimum value (MV), a requirement under the ACA that an employer-sponsored plan’s share of the total allowed cost of benefits provided under the plan be at least 60% of such costs. The rule states that employers will be able to determine whether a plan meets the MV standard by

using an MV calculator, which will be provided by HHS and the Internal Revenue Service (IRS). The calculator will be similar to an actuarial value (AV) calculator that HHS today released for use in the individual and small group markets. However, the MV calculator will rely on continuance tables and a standard population reflecting claims data of self-insured employer plans, while the AV calculator has been developed using a set of claims data weighted to reflect the standard population projected to enroll in the individual and small group markets for the identified year of enrollment. The proposed rule states that employers also can determine whether a plan meets the MV standard by using an array of design-based safe harbors published by HHS and IRS in the form of a checklist. Each checklist would describe the cost-sharing attributes of a plan that apply to the following four categories of benefits and services:

- Physician and mid-level practitioner care
- Hospital and emergency room services
- Pharmacy benefits
- Laboratory and imaging services

HHS states that the four categories of benefits and services comprise the majority of group health plan spending.

The proposed rule goes on to clarify that an employer could use a certified actuary to determine whether an employer-sponsored plan meets the MV standard only if the plan contains non-standard features and neither the MV calculator nor the design-based checklists applies to the plan.

Importantly, HHS proposes that employer contributions to a health savings account (HSA) and amounts newly made available under a health reimbursement account (HRA) be taken into account in determining MV. In the proposed rule's explanation of why such contributions should be applied toward the calculation of actuarial value for plans in the individual and small group market, HHS states that employer contributions to HSAs and amounts newly made available under HRAs "are the equivalent of first-dollar coverage for any cost-sharing requirements encountered by the enrollee and similar to other employer cost-sharing contributions to plan design." The attached methodology for the AV calculator beginning on page 11 addresses the calculation of expenses covered by HSAs and HRAs.

### **Essential health benefits**

Large group plans and grandfathered plans are not required to cover the 10 benefit categories that the ACA requires EHBs to include; however, such plans may not impose lifetime or annual limits on any essential health benefit that they do offer. Plans offered in the individual and small group markets, whether inside or outside state-based Exchanges, must cover EHBs beginning in 2014. To define EHBs, HHS proposes that states select a benchmark plan from the following four options:

1. The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
2. Any of the largest three State employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employee Health Benefits Program plan options by enrollment; or

4. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

The proposed rule gives states until the end of the 30-day comment period to choose an EHB benchmark plan or change their previous selection. In the event that states do not make a selection, the proposed rule states that HHS will select the largest small-group product in the state as the default benchmark.

HHS proposes that federally-facilitated Exchanges and state partnership Exchanges accept existing health plan accreditation from the National Committee for Quality Assurance ("NCQA") or URAC on an issuer's commercial or Medicaid lines of business until the fourth year of certification of a qualified health plan (e.g., 2016 certification for the 2017 coverage year) and provides a timeline for plans without such accreditation to obtain it.

**Insurance market reforms**

HHS' proposed rule on insurance market reforms states that health insurance issuers generally would be prohibited from denying coverage to people because of a pre-existing condition or other factor. Individuals will be required to enroll in coverage during specific open enrollment periods, but the proposed rule also provides for special enrollment opportunities in the individual market in certain cases in which other coverage is lost.

The proposed rule also provides more detail into the application of provisions of the ACA that limit insurers' ability to use age, tobacco use, family size and geography to determine premiums. For example, the proposed rule includes and seeks comment on a proposed standard age curve intended to help insurers set premiums without violating the law's 3:1 ratio for adult premiums.

The proposed rule states that health insurance issuers would be required to maintain a single statewide risk pool for each of their individual and small group markets unless a state merges the individual and small group pools into one.

In addition, the proposed rule would codify catastrophic plans be available only to 1) individuals younger than 30 when a plan year begins; and 2) people who have been certified as exempt from the individual mandate because minimum essential coverage is unaffordable or because they are eligible for a hardship exemption.

**Wellness programs**

A notice of proposed rulemaking jointly issued by the IRS, EBSA and CMS would increase the maximum permissible reward under a health-contingent wellness program from 20% to 30% of the cost of health coverage. The agencies also proposed increasing the maximum reward to as much as 50% of the cost of health coverage for programs designed to prevent or reduce tobacco use.

**More information**

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