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health care reform alert

Cigna

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EHB Final Rule, Calculators and FAQs on Preventive Care and Cost Sharing

Calculators

Actuarial Value (AV) Calculator

HHS requires use of an AV calculator by non-grandfathered health plans offered in the individual and small group markets, both on and off the Exchange. The calculator determines the health plan's level of coverage and calculates the percentage of total average costs for benefits that a plan will cover.

For instance, if a plan has an AV of 70 percent, on average, an individual would be responsible for 30 percent of the costs of all covered benefits in that plan. Plans with cost sharing features different from those available in the AV calculator will need to submit documentation in the form of actuarial certification.

- *Methodology:* http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf
- *Calculator:* http://cciio.cms.gov/resources/files/av-calculator-final-2-20-2013.xlsm

Employer Mandate Minimum Value (MV) Calculator

The MV calculator was developed based on

On February 20, 2013, the Department of Health and Human Services (HHS) issued its final rules on Standards Related to Essential Health Benefits (EHB), Actuarial Value and Accreditation. It also provided additional guidance in the form of Frequently Asked Questions.

Reminder: Only non-grandfathered insured plans in the individual and small group markets (on and off the Exchanges) are required to provide EHBs. Grandfathered individual and small group insurance policies and all insured and self-insured large group plans/policies are not required to provide EHBs, but if they do, they may not impose any annual or lifetime dollar maximums.

The final rules and FAQs include details on:

- Determining Actuarial Value (AV) and Employer Mandate Minimum Value (MV)
- Preventive care
- Cost sharing requirements
- EHB-benchmark and default plans. Notably, the benchmark for the 50 states remains the same, but for Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands, the default benchmark plan is the largest Federal Employees Health Benefits (FEHBP) plan by enrollment; Puerto Rico's is the largest small group product.

claim data that reflects typical employer-sponsored plans. This calculator will test whether an employer-sponsored group health plan provides minimum value based on the total allowed costs of benefits. It will determine whether an employee is eligible for a premium tax credit. However, various safe harbors will be available. HHS welcomes comments. There is no deadline for submission.

Health Savings Account (HSA) and integrated Health Reimbursement Account (HRA) contributions can be taken into account in the minimum value calculation. The full employer contribution for the year counts to reduce the deductible, as long as the contribution does not exceed the deductible.

For example, the MV calculator counts a $1,000 HSA employer contribution as the average dollar value it would cost to reduce a $1,000 deductible to $0.

- *Methodology:* http://cciio.cms.gov/resources/files/mv-calculator-methodology.pdf
- *Calculator:* http://cciio.cms.gov/resources/files/mv-calculator-final-2-20-2013.xlsm

With few exceptions, the final rule aligns with earlier regulatory guidance related to EHB: see the November 20, 2012 proposed rule, and the December 16, 2011 Essential Health Benefits Bulletin. There is no comment period for the final rule, but as noted in this alert, HHS requests comments on several items included in the guidance.

Highlights of the EHB Final Rule

Benchmark Plans and Provision of EHBs

- States retain the flexibility to define "habilitative benefits." If states choose not to define it, the carrier issuing the coverage will define. This is a transitional policy and HHS intends to monitor available data.
- Mental Health Parity and Addiction Equity Act (MHPAEA) applies to individual and non-grandfathered

small group markets to satisfy the requirement to cover mental health and substance abuse as an EHB.

- Insurers are permitted to offer elective abortion services, but states can choose to prohibit or require these services under state law.
- Prescription drugs are not required to be covered on a particular tier. HHS will study and take into consideration the effects of this policy. Additional guidance is expected.

Standalone Dental Plans

- Dental Off Exchange – Pediatric dental coverage can be excluded if issuers are reasonably assured that the individual has obtained pediatric dental coverage by an Exchange-certified standalone dental plan. The pediatric dental plan does not have to be purchased via the Exchange. Also, an individual or family must be offered coverage for all 10 EHB categories, either through one policy, or through a combination of a medical policy and an Exchange-certified standalone dental plan.

- Dental On Exchange – Pediatric dental coverage can be excluded from the EHB package if there is a standalone pediatric dental option available. An individual or family (with or without a child) can purchase a QHP (Qualified Health Plan) that does not cover the pediatric dental EHB without purchasing a standalone dental plan.

In conjunction with the EHB final rule, FAQs were released on Cost sharing and Preventive Services Guidance.

Cost Sharing

The final rule included additional guidance about issues related to ***cost sharing limits*** (i.e., annual deductibles and out-of-pocket (OOP) maximums).

Highlights

- The limit on a deductible applies only to non-grandfathered insured plans in the small group market.
- The limit on out-of-pocket expenses applies to individual insurance policies and to all insured and self-insured group plans (large and small, whether insured or self-insured).
- Temporary, transitional relief is provided for group plans that carve out benefits to multiple carriers/vendors (with the exception of behavioral health). For the first year only, carriers/vendors do not need to add up out-of-pocket costs as long as the limits for each do not exceed the cost sharing limits.
- Benefits provided through the same carrier/vendor (e.g., medical, pharmacy, non-excepted dental and vision) must be cross-accumulated in determining compliance with the cost sharing limits.
- Even plans that carve out behavioral health benefits must comply with MHPAEA regulations that forbid separate annual out-of-pocket maximums for medical/surgical benefits and mental health/substance use disorder benefits.

NOTE: Comments on the applicability of deductible limits to self-funded and large group are due April 22, 2013. Comments on issues related to cross accumulation of OOP limits with carve-out benefits are requested; there is no due date.

Preventive Care

HHS also provided 20 FAQs on ***preventive care***, including U.S. Preventive Services Task Force (USPSTF) recommendations, out-of-network services, women's health and immunizations.

Highlights

- Plans cannot impose cost sharing for the cost of polyp removal during a routine screening colonoscopy.
- Plans must cover, without cost sharing, genetic counseling and breast cancer susceptibility gene (BRCA) testing, if appropriate.
- Plans can use reasonable medical management techniques to require multiple prevention and screening services at a single visit; multiple visits for separate services are not required.
- Although only one annual well-woman preventive care visit is to be covered without cost sharing, if additional visits are clinically necessary to obtain all needed preventive services, those visits must also be covered without cost sharing, subject to reasonable medical management.
- For most women age 30 and older, high-risk Human Papilloma Virus (HPV) DNA testing does not need to be covered more frequently than every three years.
- Plans can cover a generic contraceptive drug without cost sharing and require cost sharing for equivalent branded drugs, unless the brand name is medically necessary per health care professional clinical judgment.
- Unless prescribed by a health care professional, plans do not have to cover over-the-counter contraceptive methods (e.g., sponges and spermicides).
- Plans do not have to cover contraception for men (e.g., condoms and vasectomies).
- Plans must cover, without cost sharing, Federal Drug Administration (FDA)-approved intrauterine devices and implants when prescribed by a health care professional.
- Plans can use reasonable medical management techniques to determine frequency, method, treatment, or setting regarding lactation counseling and breastfeeding equipment and supplies.
- If an in-network health care professional is not available for one of the recommended preventive services, the plan must cover the out-of-network service without cost sharing.
- If the Advisory Committee on Immunization Practices (ACIP) makes a vaccine recommendation for individuals rather than an entire population, and a health care professional prescribes the vaccine consistent with ACIP recommendations, plans must cover the vaccine without cost sharing.

ADDITIONAL RESOURCES

Final Rule
http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html

Fact Sheet
http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html

EHB Coverage for Mental Health and Substance Use Disorders
http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm

State-by-State Benchmark Plans
http://cciio.cms.gov/resources/data/ehb.html

Frequently Asked Questions on Cost Sharing and Preventive Services
http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs12.html#coverage

We encourage you to bookmark our health care reform website, InformedOnReform.com.