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HEALTH LAW ALERT
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HHS Proposes Essential Health Benefits, Market Rules

Proposals Establish State EHB Packages, Rating Methodologies

Today, the Department of Health and Human Services (HHS) formally published three proposed rules under the Affordable Care Act. The proposed rules address Essential Health Benefit standards, insurance market reforms, and wellness program provisions. Generally, the standards would go into effect on January 1, 2014. Many of the provisions simply codify requirements of the Affordable Care Act. But, the proposed rules explain how the "Essential Health Benefit" benchmark for each State would be determined and lists what those standards would be in each State. A State may take action to change this outcome by the end of the comment period—December 26. HHS also proposes mechanisms for how insurers may establish rates in the individual and small group markets, based on age bands, tobacco use, and geography. The proposed rules also expand the rewards (or penalties) employers and insurers may provide for participation in wellness programs.

Comments for the essential health benefits and insurance market reform provisions are due by December 26, 2012. Comments on the Wellness Program provisions are due by January 25, 2013. The proposed rules are published in today's Federal Register:

- Click here for proposed rules on Essential Health Benefits (77 *Federal Register* 70643); for the table of State-specific benchmarks, *see* pages 70673-76 (pages 31-34 of the pdf document).

- Click here for proposed rules on addressing insurance market reforms (77 *Federal Register* 70583), including requirements for setting rates based on age, geography, and tobacco use.

- Click here for proposed rules on Wellness Programs (77 *Federal Register* 70619).

Essential Health Benefits

Under guidance HHS previously published, States may choose a "base benchmark plan" from among several options, such as any of the largest three national Federal Employees Health Benefits Program plan options. The base benchmark plan in States that fail to choose a plan will be the largest small group product offered in the State. A State's base benchmark plan will then be supplemented, if necessary, with pediatric oral services, pediatric vision services, or other categories of "essential health benefits" (as defined in the Affordable Care Act) that the benchmark plan does not already include.

Generally, States may choose between benefits provided in (at least) two other benefit packages to supplement the base benchmark plan's package of benefits. Thus, a State that selects a base benchmark plan that does not cover pediatric oral services must supplement the base benchmark program with the pediatric oral services covered by either the Federal Employee Dental and Vision Insurance Program (FEDVIP) or the State CHIP program. The proposed rule establishes default choices for States that fail to select an option for supplementing the base benchmark plan with respect to categories of essential health benefits not covered by the original plan.

Once this process is complete so the benchmark plan includes all categories of essential health benefits, the plan would become the State's Essential Health Benefit- (EHB-) Benchmark plan. Beginning in 2014, the EHB-Benchmark plan "would serve as a reference plan, reflecting both the scope of services and limits" for insurance coverage offered in the individual and small group markets in the State—both inside and outside of Exchanges. A State's choices (or the default options in States that do not make choices) will be in effect "for at least the 2014 and 2015 benefit years."

The chart published in Appendix 1 of the proposed rule sets out the choices each State has made (or the default options applied to States that have not made choices) with respect to their EHB-Benchmark plans. Click here to see the chart. *See* pages 70673-76 (pages 31-34 of the pdf document).

Insurance Market Reforms

Single Risk Pool. The proposed rules implement the Affordable Care Act's insurance market reforms concerning premium rating, guaranteed availability, guaranteed renewability, and risk pools. HHS explains that the Affordable Care Act requires each insurer to treat all of its business in a State's individual market as one single risk pool and all of its business in a State's small group market as a single risk pool.[1] The single risk pool must include business inside and outside of Exchanges. This policy would have significant implications for rates. Specifically, an insurer would be required to establish an index rate for its individual business and an index rate for its small group business. Those index rates "would be utilized to set the rates for all [of the insurer's] non-grandfathered plans" in the individual and small group markets (respectively). The premium rate for a particular individual (or small employer) "could not vary from the resulting index rate," except for specified reasons, such as the actuarial value and cost-sharing design of the plan and provider network and delivery system characteristics.[2]

[1] States may elect to treat the individual and small group markets as one risk pool.

[2] This provision would not affect an insurer's ability to charge premium based on family size, geographic rating area, age, and tobacco use as allowed by other provisions of the Affordable Care Act and these proposed rules.

Age Rating. The Affordable Care Act allows insurers to vary rates based on age by no more than a 3-1 ratio. HHS proposes to specify how insurers accomplish this. The proposed rule would require insurers to use "uniform age bands" when establishing rates and would apply a "uniform age curve" to determine rate differentials based on age. Specifically, HHS proposes to adopt one-year age bands from age 21 to 63, a single age band for those 64 and over, and another age band for children 0-20. Under HHS's uniform age curve proposal, a policy that costs a 21-year old $1,000/month would cost:

- A child (under 21) $635;
- A 30-year old $1,135;
- A 40-year old $1,278;
- A 50-year old $1,786;
- A 60-year old $2,714; and
- A person 64 or older $3,000.

HHS concludes that one-year age bands would result in "steady, relatively small premium increases each year due to age." The same age-rating scheme would apply in the individual and small group markets, both inside and outside Exchanges. A State may adopt a different "uniform age curve."

Rating Based on Geography and Tobacco Use. HHS would permit States to establish up to seven geographic rating areas, in which insurers could vary their rates based on geographic differences in the cost of care. But, any geographic rating system would be applied uniformly to all insurers in the state.

Although the Affordable Care Act allows insurers to impose a surcharge of 50% on members who use tobacco, the proposed rules would treat any surcharge in the small group market as a wellness program. Under the proposal, an insurer would not be allowed to assess the surcharge unless the surcharge was imposed in the context of a wellness program, meaning the insurer would be required to allow a smoker to avoid the surcharge by meeting a "reasonable alternative standard," such as attending a smoking cessation program.

Prohibition on Composite Rating. The proposed rule would prohibit the practice of "composite rating"—using average ages (and other factors) of participants in a small group to determine the group's premium. Rather, insurers will be required to use "per-member rating," under which the insurer calculates premium "by totaling the premiums attributable to each covered individual," including covered family members. HHS explains that this is necessary to apply rates based on age and tobacco use to each individual as required by the Affordable Care Act.

Wellness Program Rule and Non-Discrimination Provisions. The Affordable Care Act gave insurers and employers greater flexibility in establishing wellness programs by increasing the value of rewards (and penalties) that may be used in such programs. In addition to allowing rewards (or penalties) of up to 30% of the cost of coverage, the Affordable Care Act granted HHS the authority to further increase rewards (or penalties) to 50% of the cost of coverage. HHS's proposed rules codify the increase in permissible wellness program awards to 30% and establishes a 50% limit on wellness programs related to tobacco use. HHS proposes to apply the standards to grandfathered plans, as well as non-grandfathered plans.

Prior to the Affordable Care Act, only the small group and large group markets were subject to the HIPAA-non-discrimination provisions, which prohibit discrimination based on a health factor. The Affordable Care Act applies these provisions to the individual market. The proposed rule codifies these changes. Nevertheless, the Wellness Program Rule[3] will not apply to the individual market.

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[3] The Wellness Program Rule, 45 C.F.R. § 146.121(f), is an exception to the HIPAA non-discrimination rules.