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Web Meeting Q&A Summary

This FAQ overview summarizes the question and answer session that followed Cigna's September 25, 2013 Informed on Reform Web Meeting.

Essential Health Benefits, Cost-Sharing Limits and Your Benefit Plan Designs

Frequently Asked Questions and Answers

Cigna's answers are based on our current understanding of the Patient Protection and Affordable Care Act (PPACA) as of September 25, 2013. We received many questions related to a number of topics and provisions of the law during the web meeting. If we did not cover your question, please visit InformedOnReform.com for further information.

ESSENTIAL HEALTH BENEFITS

Q1: What are essential health benefits?

Essential health benefits (EHBs) are the 10 categories of benefits that all non-grandfathered insured individual and small group plans must offer beginning in 2014 whether the insurance coverage is obtained through an Exchange/Marketplace or off the exchange. Self-insured small group plans, large group plans and grandfathered plans are not required to offer essential health benefits, but if they do offer any essential health benefits, they cannot have any annual or lifetime dollar limits.

Q2: How are essential health benefits different from minimum essential coverage?

Minimum essential coverage refers to the "individual mandate" which requires all individuals to have "minimum essential coverage" beginning in 2014 or pay a tax penalty. While one would expect that "minimum essential coverage" would be defined with reference to minimum benefits, it's not. Instead, "minimum essential coverage" is defined to mean coverage under certain types of plans including employer-sponsored plans, individual plans and government plans.

Q3: How are essential health benefits determined?

There is no national definition of essential health benefits. Each state has selected an existing health plan as a benchmark plan to establish the services considered essential health benefits in that state. Each self-insured group health plan must select a state for the purpose of determining their plan's essential health benefits. Fully insured plans defer to the situs state to determine their plan's EHBs.

Q4: If we have an ERISA plan, we do not need to comply with state regulations. How does that impact essential health benefits?

While it's correct that self-funded ERISA plans are not required to comply with state law, essential health benefits are not considered state requirements. HHS was tasked with defining the EHB services that fall within the 10 broad categories. HHS chose to accomplish this by allowing each state to select a benchmark plan. Federal guidance requires that EHB services be defined by that benchmark plan. HHS will not be providing a definition. Therefore, all plans (ERISA and non-ERISA), regardless of funding, must pay attention to essential health benefits.

Q5: Why does a self-insured client need to select an EHB benchmark state?

Even though self-insured plans and insured plans in the large group market are not required to offer essential health benefits, they typically do provide coverage for some if not most essential health benefits. As a result, they still need to ensure that their plans comply with the ban on annual and lifetime maximums and the cost-sharing limits. Both requirements apply to any essential health benefits that may be offered by self-insured plans.

For self-insured plans, the plan sponsor must select a benchmark state so that its administrator will know what benefits are considered essential health benefits for purposes of administering annual or lifetime benefit limits or any cost-sharing limits. If the plan sponsor doesn't identify the benchmark state it wants to use, the administrator cannot ensure the plan will be compliant with PPACA on the employer's behalf.

Only in the situation where the plan has no annual or lifetime limits and the plan sponsor determines that all cost-sharing will accumulate toward the out-of-pocket (OOP) cost-sharing limits is it not necessary to select a benchmark state.

Q6: Can a client change its EHB benchmark state at renewal?

The government has not issued any guidance on this, so our current assumption is that the EHB state selection can change each plan year.

Q7: Do employers who operate in multiple states have to comply with multiple states' EHBs?

No. An employer only needs to identify one state's EHBs for each group health plan. Self-insured employers don't have to choose the state where they are headquartered or the state where they have the most employees. They can compare the EHBs for various states and choose any state.

Q8: For essential health benefits, will limits on the number of services be allowed in lieu of dollar maximums? For example, can a plan allow only 10 visits for a certain service?

Yes. PPACA only prohibits annual and lifetime limits on the dollar amount of essential health benefits. Plans may include day or visit limits as long as there's not a dollar amount associated with them. A dollar amount per day equates to an annual or lifetime dollar limit and is not permitted. A dollar limit per visit will also equate to an annual or lifetime dollar limit if the plan also limits the number of visits per year/lifetime.

Small group plans must match any limits in the benchmark plan. For example, if the benchmark plan covers 60 days of skilled nursing, a small group plan must match that benefit or provide the actuarial equivalent if it's a dollar limit. Large group and self-insured plans do not need to match the day or visit limits of the benchmark plan.

Because the claims for some services or treatments are not easily processed in days or visits, it's important to discuss this with your insurer or administrator to make sure the limits you are considering can be administered.

Q9: If a state does not define a benefit such as infertility as an EHB, can a plan include that benefit with limits?

Yes. If a benefit is not defined as an EHB, it can be covered with annual or lifetime limits.

Q10: Could a plan limit the number of prescriptions an individual can fill each year?

Technically, that would be allowed since it's not a dollar limit. However, if an employer is concerned about controlling prescription drug costs, Cigna offers many programs to help manage pharmacy costs. Step therapy and incentives for switching from brand name to generic drugs or filling maintenance drugs by mail can help reduce drug costs. In addition, our online price quote tool allows customers to compare costs between brand and generic drugs and see how home delivery saves money compared to filling prescriptions at a retail pharmacy. If controlling costs is the goal, these programs are examples of demonstrated ways to reduce pharmacy expenses.

Q11: Why do some benchmark benefits currently have annual limits? For example, some state benchmark plans have a $1,500 annual limit on hearing aid coverage.

The benchmark plans are based on plans that were in effect in 2011. At that time, some services had dollar limits. For 2014, those dollar limits can no longer apply.

COST-SHARING LIMITS

Q12: What are the cost-sharing limits?

Beginning in 2014, in-network out-of-pocket maximums for all non-grandfathered plans are limited to $6,350 for individual coverage and $12,700 for family coverage. The out-of-pocket maximum must include all copays, deductibles and coinsurance for all in-network benefits.

Q13: Does the out-of-pocket maximum requirement apply to both in-network and out-of-network benefits?

No. The out-of-pocket maximum limit applies only to in-network benefits.

Q14: Is there an exception in 2014 for carved-out benefits?

Yes. If a group health plan or insurer uses two or more service providers to administer benefits subject to the cost-sharing limitation, there was a recognition that it may take additional time for these different service providers to coordinate their activities and make the system changes necessary to cross-accumulate cost-sharing amounts as required by the law.

So in situations where the administration of prescription drug coverage, for example, is carved out to a different party than the one administering the medical plan, transitional relief for one year is available, but only if two conditions are met:

- The plan must comply with the cost-sharing limits for its medical coverage.
- The out-of-pocket maximum for the carve-out benefit must also comply with the PPACA limit.

It should be noted that this transitional relief does **not** apply to carved-out mental health and substance abuse coverage. Due to the requirements of the Mental Health Parity Act, there cannot be separate OOP maximums for mental health/substance abuse benefits and other medical benefits unless the plan was previously permitted to opt out of the Mental Health Parity Act requirements.

Finally, the transitional relief applies only for plan years beginning on or after January 1, 2014. All cost-sharing must accumulate toward the out-of-pocket limit for plan years beginning on or after January 1, 2015.

Q15: Does an employer have to apply or be approved to take advantage of the transitional relief for 2014 when their plan has multiple service providers?

No. There is no application, review or approval process. Any employer that meets the requirements can take advantage of the transitional relief.

Q16: Does the transitional relief for prescription drugs apply only for carved-out benefits?

Yes. If prescription drugs are part of the medical plan and are provided by the same company that administers the medical plan, prescriptions must accumulate toward the medical plan's out-of-pocket maximum in 2014.

Q17: What if our plan does not renew until the middle of the year? Are the copays still going to be applied toward the out-of-pocket maximum starting January 1, 2014?

No. The cost-sharing limits apply for plan years beginning on or after January 1, 2014. In this example, copays would not need to be applied to the OOP maximum until the start of the plan year that begins in 2014.

Q18: For non-grandfathered, insured small group plans where the maximum deductible allowed is $2,000, can an employer contribute $500 to a health reimbursement account, health savings account or flexible spending account (an HRA, HSA or FSA) toward a $2,500 deductible plan and be compliant with the $2,000 deductible maximum for 2014?

No. The regulations do not allow employer contributions to an HRA/FSA/HSA to be considered in determining whether the plan meets the $2,000 deductible.

EXCEPTED BENEFITS

Q19: Can you explain the difference between excepted and non-excepted benefits?

Certain types of benefits are excepted from the application of federal laws such as PPACA. These are called "excepted benefits."

Examples of "excepted benefits" include vision and dental benefits when offered under an insurance policy that is separate from the medical policy. For self-insured plans, the dental or vision benefits cannot be an integral part of the group health plan. That means:

- Employees must be permitted to enroll in or decline the dental or vision coverage separately from medical, **and**
- If they choose dental or vision, the employee must pay an additional premium for that coverage.

Q20: Must dental benefits for children be part of the medical plan, or does a stand-alone dental plan comply?

While essential health benefits include pediatric dental benefits, remember that only non-grandfathered, insured individual and small group plans are required to offer essential health benefits. Self-insured plans, insured group health plans sponsored by employers with more than 50 full-time or full-time equivalent employees and grandfathered plans are not required to cover essential health benefits.

Insurers offering individual and small group insured plans are required to offer essential health benefits and must, therefore, include pediatric dental coverage in their insurance policies unless the individual certifies that he/she has stand-alone dental coverage.

OTHER PPACA PROVISIONS

Q21: If a self-insured group is a hospital, can the hospital designate only its own facilities and doctors as in-network providers?

Yes. But there could be a concern about adequate access if certain types of specialists are not available or if some employees have to travel long distances to receive care. However, the out-of-pocket limits apply to all in-network services, even if the plan has multiple in-network levels.

Q22: If an employer offers coverage that provides minimum value and is affordable based on the cost of employee-only coverage, does that disqualify employees' dependents from receiving a subsidy if they buy coverage through the Marketplace?

Yes. It is our understanding that this is true.

Q23: Can large groups change their plan year to renew in December 2013 so they can continue their current benefits through most of 2014?

Some individual and insured small group plans are making these types of changes to delay the community rating provisions that are effective the first of the year. They are changing their policy year to renew in December 2013 so they do not have to comply with the 2014 PPACA requirements until December 2014. Changing the plan year solely to delay compliance with PPACA is **not** a strategy we would recommend for large group plans.