United Actuarial Services, Inc.
Actuaries and Consultants

2012-67

December 13, 2012

BENEFIT NEWS BRIEFS

HHS Releases Proposed Regulations on Essential Health Benefits, Minimum Value and More

The Department of Health and Human Services (HHS) released proposed regulations covering a number of items related to implementing the *Affordable Care Act (ACA)*. Items of relevance to multiemployer health plans include the definition of Essential Health Benefits (EHB) and the proposal to develop a Minimum Value calculator for employers to use to determine if their health plans provide Minimum Value to their employees.

The proposed regulation addresses other matters that are related to Qualified Health Plans (QHPs) under the health care exchanges, as well as rules for calculating actuarial value for non-grandfathered individual and small-group policies among other matters. A brief discussion of EHBs and Minimum Value relevant to multiemployer health care plans follows.

Essential Health Benefits

Consistent with the HHS EHB guidance discussed in *Benefit News Briefs 2012-01*, HHS proposes that each State be allowed to choose a "benchmark" health plan based on employer-sponsored coverage in the marketplace to define the parameters of each of the 10 statutory categories of EHBs. A process is also set out whereby a default benchmark plan will be chosen for the state fails to designate a benchmark plan.

To help states make their benchmark selections, HHS has provided states with benefit data on the largest plans by enrollment in the three largest small group insurance products in each state's small group market as of the first quarter of calendar year 2012. This data is available *by "clicking here" or* at: *http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF.* The linked document has further links to benefit descriptions of benefits offered by some plans. More information and links to each state's benchmark plan is available at: *http://cciio.cms.gov/resources/data/ehb.html.*

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This information is interesting as it gives an idea of what atypical services such as *"habilitative"* services and further refines "*pediatric services, including oral and vision care.*" The *Preamble* notes that pediatric services means services to age 19. (see proposed rules at 70649, right col.)

EHBs must include items and services within at least the following 10 categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management and (10) pediatric services, including oral and vision care.

Under Section 1302(b) of the *ACA*, EHBs must be covered by:

- non-grandfathered plans in the individual and small group markets both inside and outside of the Health Insurance Exchanges,
- Medicaid benchmark and benchmark-equivalent, and
- Medicaid Basic Health Programs beginning in 2014.

However, the term "EHB" is not limited in applicability to the coverage required under Section 1302(b) and this is where any discussion of EHBs can get confusing. While the requirement to cover EHBs is limited to the above types of insured plans, the definition of EHB will have an indirect impact on other types of plans covered by the *ACA* such as self-insured group health plans (GHPs), including multiemployer plans.

One reason for possible confusion is because the term EHB is also used in *ACA* Section 1001 in reference to changes to the rules prohibiting lifetime limits and setting rules on annual limits. The implementing regulation at *ERISA* Section 2590.715-2711 states in part:

> The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are <u>not</u> *essential health benefits* to the extent that such limits are otherwise permitted under applicable Federal or State law. (emphasis added)

This *ERISA* regulation defines EHBs by referring to the EHBs under *ACA* Section 1302, as discussed above. Thus, the definition of EHB will be useful in applying "annual" limits on benefits that are <u>not</u> considered EHBs. It is for this reason that the definition of EHB is important to multiemployer plans.

Minimum Value

The calculation of Minimum Value is important in order to help large employers determine if they might be liable for a penalty under the *ACA* for failing to provide their employees an opportunity to enroll in employer-sponsored health coverage.

Generally, Code Section 4980H provides that a large employer (50 full-time employees or more) is subject to an assessable payment if any full-time employee (30 or more hours average a week) is:

- certified to receive a premium tax credit or cost-sharing reduction **and**

- **either**
  (1) the employer does not offer its full-time employees (and their dependents) the opportunity to enroll in *minimum essential coverage* under a employer-sponsored plan (the "Section 4980H(a) penalty"); **or**

  (2) the employer offers its full-time employees (and their dependents) the opportunity to enroll in *minimum essential coverage* that is either:

  - *unaffordable* (costs more than 9.5% of the employee's gross income); or

  - does not provide "*minimum value*" – (*minimum value* must have an actuarial value of at least 60% (the "Section 4980H(b) penalty")).

A plan fails to provide minimum value if "the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs."

HHS proposes that employer-sponsored self-insured and insured large group plans will be able to use the Minimum Value calculator, which will be made available by HHS and the Internal Revenue Service (IRS). The Minimum Value calculator will be based on continuance tables and a standard population reflecting claims data of typical self-insured employer plans. This approach would permit an employer-sponsored plan to enter information about the plan's cost sharing to determine whether the plan provides Minimum Value.

As an alternative to using the Minimum Value calculator, HHS proposes that an employer-sponsored plan would be able to use design-based safe harbors published by HHS and the IRS in the form of checklists to determine whether the plan provides Minimum Value. Each safe harbor checklist would describe the cost sharing attributes of a plan that apply to the following four core categories of benefits and services which comprise the vast majority of group health plan spending as described in the Minimum Value Notice: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits and laboratory and imaging services.

Finally, if an employer-sponsored plan contains non-standard features not suitable for the use of the Minimum Value calculator and do not fit the safe harbor checklists, HHS proposes to permit Minimum Value to be determined through certification by an actuary without the use of the Minimum Value calculator. This final option would be available only when one of the other methodologies is not applicable to the employer-sponsored plan. This Minimum Value determination must be made by a member of the American Academy of Actuaries (MAAA), in accordance with generally accepted actuarial principles and methodologies.

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