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Final guidance issued on essential health benefits and cost-sharing requirements

Final regulations on the determination of essential health benefits and the actuarial and minimum value requirements have been published. The regulations also discuss how the deductible and out-of-pocket cost-sharing limitations apply to health plans and provide, among other things, that non-grandfathered plans, including self-funded employer plans, will be subject to annual limits on their out-of-pocket maximums. These limits will be based on the out-of-pocket limits applicable to high-deductible health plans that are compatible with health savings accounts. Also, subregulatory guidance was released in the form of Frequently Asked Questions (FAQs) that provide some transition relief for implementing the new out-of-pocket maximum limits. The new out-of-pocket maximum will require most plan sponsors to redesign their plans for 2014, and will result in higher plan costs.

Background

Beginning in 2014, all non-grandfathered health plans sold in the individual and small group markets (both inside and outside ACA Exchanges) must:

- Cover all ten categories of essential health benefits (EHB)
- Meet annual cost-sharing limits on EHB
- Meet actuarial value limits for EHB

Although large group health plans do not have to cover EHB, they must satisfy “minimum value” requirements to avoid potential liability for the ACA shared responsibility penalties. In addition, they cannot impose any annual or lifetime dollar limits on EHB.

On November 26, 2012, the Department of Health and Human Services (HHS) published proposed rules that addressed these issues. (See our January 10, 2013 *For Your Information*.) On February 20, 2013, HHS issued final regulations, which were published in the Federal Register on February 25, 2013. While these final regulations largely follow the proposed regulations, they do provide additional guidance in several areas, including

the application of the annual limits on cost sharing on EHB to self-insured and large group health plans, and the determination of whether an employer-sponsored plan provides minimum value.

On February 20, 2013, the Departments of Labor, HHS, and Treasury (collectively, the Departments) released a set of Frequently Asked Questions (FAQs Part XII) that discuss the limitations on cost sharing and coverage of preventive services under ACA.

Essential health benefits

Beginning in 2014, all non-grandfathered health plans in the individual and small group markets will be required to cover ten categories of EHB. Each state had until December 26, 2012, to select a benchmark health plan for determining EHB from among several options; if a state did not select a benchmark plan, HHS would select the default base-benchmark plan. The benchmark health plan serves as a reference plan for the state, reflecting both the scope of and limits on EHB for that state. On February 20, 2013, HHS released the list of final benchmark plans for each state.

Large employer plans, whether insured or self-funded, are not required to cover EHB. However, because these plans, including plans that are still grandfathered, are prohibited from imposing annual or lifetime dollar limits on EHB, it is important that plan sponsors know which benefits are EHB.

> Buck comment. The final regulations do not provide any additional guidance on what are considered EHB for purposes of the prohibition on annual and lifetime dollar limits for large group health plans. HHS has stated that large group market plans, self-insured group health plans, and grandfathered group health plans will be considered to have used a permissible definition of EHB "if the definition is one that is authorized by the Secretary of HHS. Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB."
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> Self-insured and large group plans will need to determine which definition of EHB they will utilize for 2014, review any annual or lifetime dollar limits that apply to any EHB in the plan, and make any needed modifications. For example, if the plan has dollar limits on chiropractic or infertility benefits, and those benefits are considered EHB under the definition used by the employer, any annual or lifetime dollar limits on those benefits must be removed. Therefore, deciding on the definition of EHB used by an employer plan will be an important determination.

Cost-sharing requirements

Effective for plan and policy years beginning on or after January 1, 2014, ACA imposes annual limits on the amount that an enrollee in a non-grandfathered plan must pay for EHB through cost sharing. The proposed regulations confirmed that the out-of-pocket maximums applied to individual and small group health plans, but did not address whether they applied to self-insured and large group health plans. The final regulations now provide clarification.

Out-of-pocket maximum limits

The final regulations confirm that the out-of-pocket maximums for cost sharing also apply to non-grandfathered self-insured and large group health plans. Cost sharing for this purpose includes deductibles, coinsurance, and copayments for in-network providers. It does not include premiums, non-covered services, balance billing amounts, or cost sharing for out-of-network providers. In 2014, this enrollee cost-sharing limit will be based on the amounts allowed for high-deductible health plans (HDHPs) coordinated with health savings accounts (HSAs). (In 2013 these amounts are $6,250 for self-only coverage and $12,500 for other than self-only; 2014 HSA limits will likely be announced in May, 2013.) The 2014 limits will be indexed in future years.

> Buck comment. Since most group health plans do not credit copayments towards the out-of-pocket maximums, this change will require many employers to modify their plan design and administration, and it will increase plan costs. Some plans will also need to reduce their out-of-pocket maximums to meet the new requirements.
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> This requirement does not apply to grandfathered plans or "retiree only" plans. Since the out-of-pocket maximum only applies to EHB, any benefits covered under a health plan that are not EHB will not be subject to the limit. Plans will also need to coordinate the payment of provider copays, paid at the time of service, with the satisfaction of out-of-pocket maximum.

Transition rule for 2014 plan year. Recognizing that plans utilizing multiple service providers (such as separate administrators for medical and pharmacy coverage) may have difficulty complying with the out-of-pocket maximums in 2014, the Departments set out a special transition rule in Q2 of the FAQs. Under this rule, which only applies for the first plan year beginning on or after January 1, 2014, the Departments will consider a group health plan that utilizes more than one service provider to administer benefits as satisfying the limit on out-of-pocket maximums if the following conditions are met:

- The plan complies with the out-of-pocket maximum for medical coverage (excluding, for example, prescription drug coverage).
- If the plan includes an out-of-pocket maximum on coverage that is not solely major medical coverage (for example, a separate maximum for prescription drugs), that out-of-pocket limit also complies with the maximums.

> Buck comment. Importantly, under this transition rule, plans that do not have an out-of-pocket maximum on non-major medical coverage (e.g., prescription drugs), administered by a separate service provider, do not have to implement an out-of-pocket maximum for 2014 for that coverage.

Deductible limits

Small group health plans are also subject to a limit on the amount of their annual deductibles. In 2014, these limits will be $2,000 for self-only coverage and $4,000 for other than self-only coverage. The amounts will be indexed in future years.

> Buck comment. Q1 of the FAQs states that while the Departments continue to believe the deductible limits only apply to small group health plans, they intend to engage in future rulemaking on this issue. The Departments invite comments on the application of the deductible limits to plans other than small

group health plans. Self-insured and large group health plans can rely on the HHS guidance regarding deductibles until other regulations are released.

Actuarial value

Starting in 2014, all non-grandfathered health plans in the individual and small group markets (both inside and outside the ACA Exchanges) must provide coverage that meets certain distinct levels of coverage. The levels of coverage are based on the actuarial value (AV) of the plan – commonly called the "metal levels."

Health plan metal level	Actuarial value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

If a health plan is expected to reimburse, on average, 80% of the eligible EHB covered under the plan, the AV is 80%. An individual covered by the plan would pay, on average, the remaining 20% through features such as deductibles, copayments, and coinsurance. AV can be considered a general measure of generosity – the higher the AV, the more generous the coverage provided by the plan. Annual employer contributions to health savings accounts (HSAs) and newly available employer contributions to health reimbursement accounts (HRAs) that only can be used for cost sharing (i.e., integrated with the employer-sponsored plan) will be reflected in determining AV. However, as under the proposed regulations, the employer account contributions will be "adjusted to reflect the expected spending for health costs in a benefit year."

HHS has finalized the AV calculator that will be used to determine AV. While HHS anticipates that most plans will be able to use the AV calculator, the guidance provides alternatives for determining AV for plans that are not compatible with the AV calculator.

Minimum value

Beginning in 2014, if an employer does not offer a health plan that has a "minimum value" (MV) of at least 60%, its employees who enroll in an Exchange plan may be eligible to receive a federal premium subsidy or qualify for reduced cost sharing. Under ACA's "shared responsibility" provisions, the employer could be subject to a $3,000 penalty for each full-time employee who receives subsidized Exchange coverage.

The final regulations include the same approaches for determining MV that were included in the proposed regulations:

- **MV calculator** – An MV calculator is now available on the HHS website. It is similar in design to the AV calculator. However, it is based on claims data for typical self-funded employer plans. HHS is accepting comments on the MV calculator.

- **Design-based safe harbor checklists** – HHS and the IRS will publish an array of design-based safe harbors in the form of checklists to determine whether a plan provides MV. These checklists are not yet available.
- **Actuarial certification** – If a plan contains non-standard plan features where neither the MV calculator nor the safe harbor checklists can be used, then a member of the American Academy of Actuaries can provide certification that the plan satisfies the MV requirement.

Importantly, employer contributions to an HSA or amounts newly made available under an HRA that can only be used for cost sharing (i.e., integrated with the employer-sponsored plan) will also be taken into account in determining MV, using the same principles as for AV. Therefore, the full value of the employer contribution will not be included in the MV.

> Buck comment. Buck's analysis using the HHS MV calculator indicates that most employer plans will easily satisfy the 60% minimum value requirement. Even though the full value of employer HSA and HRA contributions will not be included in the MV, Buck's analysis also shows that most plans with HDHP/HSA will satisfy the 60% MV requirement even with no employer HSA contribution. Plans sponsors should review their plans to determine their minimum value.

In closing

Plan sponsors will need to review the current out-of-pocket maximum plan design and consider any required modifications to comply with these new requirements. Sponsors of plans with more than one service provider should consider the use of the transition rule for 2014. Plan sponsors also need to determine the definition of EHB that will be used for its plans and determine if any annual or lifetime dollar limits on EHB must be removed for 2014.

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