



February 20, 2013

HHS releases final rule on minimum value standard for employer plans, essential health benefits under ACA

The Department of Health and Human Services (HHS) today (February 20, 2013) released a final rule on the definition of essential health benefits (EHBs) and the determination of actuarial value in the individual and small group markets, as well as the minimum value standard for large employers. Under the ACA, large employers could face excise taxes if full-time employees with household income between 100% and 400% of the federal poverty line receive a premium assistance tax credit to purchase Exchange coverage because the employer did not offer minimum essential coverage or because the coverage the employer offered did not meet the minimum value standard (i.e., cover at least 60% of the total allowed cost of benefits covered under the plan). Full-time employees also could receive tax credits for Exchange coverage if the employee's premium share for self-only coverage offered by an employer exceeds 9.5% of household income.

The rule is scheduled for publication in the February 25, 2013, *Federal Register*, and it will take effect 60 days later.

Key provisions of the rules are highlighted below.

Minimum value, actuarial value

The rule does not make major changes to minimum value provisions laid out in a proposed rule from HHS published in the November 26, 2012, *Federal Register*, and in Treasury Notice 2012-31. The rule outlined a number of ways to determine whether employer-sponsored self-insured group health plans and insured large group health plans meet the MV standard:

MV calculator. The rule states that employers will be able to determine whether a plan meets the MV standard by using an MV calculator, which HHS and the Internal Revenue Service posted online today. The calculator is similar to an actuarial value (AV)

calculator that HHS also released today for use in the individual and small group markets. However, the MV calculator relies on continuance tables and a standard population reflecting claims data of self-insured employer plans, while the AV calculator has been developed using a set of claims data weighted to reflect the standard population projected to enroll in the individual and small group markets for the identified year of enrollment.

Design-based safe harbors. The proposed rule states that employers also can determine whether a plan meets the MV standard by using an array of design-based safe harbors published by HHS and IRS in the form of a checklist. As outlined in the November 26, 2012, proposed rule, each checklist would describe the cost-sharing attributes of a plan that apply to the following four categories of benefits and services:

- ▶ Physician and mid-level practitioner care
- ▶ Hospital and emergency room services
- ▶ Pharmacy benefits
- ▶ Laboratory and imaging services

HHS has stated that the four categories of benefits and services comprise the majority of group health plan spending.

Certified actuary. Employers could use a certified actuary to determine whether an employer-sponsored plan meets the MV standard only if the plan contains non-standard features and neither the MV calculator nor the design-based checklists applies to the plan.

Small group market metal categories. The final rule states that any plan in the small group market that provides the bronze, silver, gold or platinum level of coverage based on an actuarial value test will be considered to satisfy the MV requirement.

The final rule clarifies that employer contributions to a health savings account (HSA) and amounts newly made available under an integrated health reimbursement account (HRA) that may be used only for cost sharing will be taken into account for determining MV. An accompanying Minimum Value Calculator Methodology document explains that the MV calculator treats such contributions as covered “first-dollar” spending for covered services (see page 8 of “*Minimum Value Calculator Methodology*”). In addition, the final rule’s preamble states that the Administration is giving “further consideration” to the question of whether other integrated HRAs might be counted toward MV.

HHS asks that technical issues and operational concerns about the MV calculator be sent to minimumvalue@cms.hhs.gov.

Essential health benefits

Large group plans and grandfathered plans are not required to cover the 10 benefit categories that the ACA requires EHBs to include; however, such plans may not impose lifetime or annual limits on any essential health benefit that they do offer. Plans offered in the individual and small group markets, whether inside or outside state-based Exchanges, must cover EHBs beginning in 2014. To define EHBs, HHS proposed that states select a benchmark plan from the following four options:

1. The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
2. Any of the largest three State employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employee Health Benefits Program plan options by enrollment; or
4. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

Twenty-six states selected their own benchmark plan from the above options, and HHS designated the largest small-group product in the state as the default benchmark in the remaining states.

The rule requires qualified health plans (QHPs) in an Exchange to cover either one drug in each class or as many drugs as are covered in the state benchmark plan, whichever is greater. The November 26, 2012, proposed rule would have required QHPs to cover just one drug per class. HHS will issue future guidance directing plans to include procedures to allow individuals to gain access to clinically appropriate drugs.

Stand-alone dental coverage. With regard to the pediatric dental coverage category of EHB, the final rule states that stand-alone dental plans will be subject to a "reasonable" out-of-pocket maximum separate from the out-of-pocket maximum for the rest of the EHBs covered by QHPs in an Exchange. Exchanges will determine what constitutes a "reasonable" out-of-pocket maximum.

In addition, the final rule recognizes that the actuarial value calculator available for QHPs "would be inappropriate for stand-alone dental plans" and provides for stand-alone dental plans to be categorized as "high" (actuarial value of at least 85%) or "low" (actuarial value of at least 70%, reduced from 75% in the November 26, 2012, proposed rule). The rule requires the above actuarial values to be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.

The final rule also states that plans outside of the Exchange may sell products that do not include pediatric dental coverage if they are "reasonably assured" that such coverage is sold only to individuals who purchase Exchange certified stand-alone dental plans.

More information

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