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EHBs, "Out of Pocket" Limits, and Minimum Value

Essential Health Benefits: A final rule under the healthcare reform law has been announced that sets standards for a core package of benefits, called essential health benefits (EHBs). Beginning in 2014, these EHBs must be covered by individual and small group health insurance issuers, both inside and outside the health insurance exchanges. The rule finalizes a benchmark-based approach allowing states to select a benchmark plan from options offered in the market, which are equal in scope to a typical employer plan. Twenty-six states selected a benchmark plan for their state, and the largest small business plan in each state will be the benchmark for the rest. The rule outlines actuarial value levels in the individual and small group markets, which helps to distinguish health plans offering different levels of coverage. Beginning in 2014, plans that cover EHBs must cover a certain percentage of costs, known as actuarial value or “metal levels.” The Center for Consumer Information & Insurance Oversight published a fact sheet on the rule.

Though the healthcare reform law does not require employer-sponsored plans to cover EHBs, group health plans, including self-insured employer-sponsored plans, to the extent that they cover EHBs, must have no lifetime dollar limits on EHBs and must phase out annual dollar limits on these benefits by plan years beginning on or after January 1, 2014. Self-insured and large-insured plans can use any HHS-authorized EHB definition when complying with the lifetime and annual dollar limit rules. This means that self-insured and large-insured plans will need to examine state and federal EHB definitions to determine which EHB definition will best suit their compliance needs.

Out-of-Pocket Limits: The final rule also addresses an issue of direct concern to sponsors of self-insured and large-insured group plans regarding the application of “out-of-pocket” (OOP) cost-sharing limits. The final rules, together with a new Frequently Asked Questions (FAQ) document clarify that self-insured and large-insured group health plans do not have to comply with the $2,000 and $4,000 deductible limits (for self-only and family coverage, respectively) that apply to plans and issuers in the small group market beginning in 2014. The guidance also provides that for plan years beginning on or after January 1, 2014 (or upon loss of grandfathered status, if later), all non-grandfathered group health plan OOP cost-sharing limits (i.e., coinsurance, deductibles, copayments, and similar charges) cannot exceed the Health Savings Account (HSA) OOP limits: $6,250 for self-only coverage and $12,500 for family coverage (based on 2013 limits). For plan years after 2014, these limits will increase based on a formula tied to average per capita premiums for health insurance coverage in the United States.

The rules recognize that plans may utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization). Separate plan service providers may impose different levels of OOP limitations and may utilize different methods for crediting participants' expenses against any OOP maximums. To address this, for the first plan year beginning on or after January 1, 2014 only, the agencies will treat plans as satisfying the OOP limit requirement if: (1) they comply with respect to major medical coverage (excluding, for example, prescription drug and pediatric dental coverage) and (2) any separate OOP maximums for coverage that is not considered major medical (such as prescription drug) do not, by themselves, exceed the HSA out-of-pocket limits described above. Plans must still comply with Mental Health Parity and Addiction Equity Act (MHPAEA) regulations, which prohibit separate, annual OOP maximums for medical/surgical benefits and mental health/substance use disorder benefits, even if plans carve the latter out.

Minimum Value: The final rule also addresses the methods for determining whether employer-sponsored coverage provides “minimum value” for purposes of the employer-shared-responsibility penalties. The final regulations generally adopt the methodology established in earlier proposals for determining whether an employer-sponsored plan satisfies the 60% minimum value (MV) requirements. Generally, these methods determine MV in a manner consistent with HHS rules for calculating the actuarial value of exchange plans, with adjustments for claims data typical of self-insured plans, covered benefits, and employer HSA and HRA contributions. These include the following:

- *Agency-Developed Calculator.* The agencies have developed a minimum value calculator, accompanied by an explanatory Minimum Value Calculator Methodology, that employer-sponsored plans can use to make minimum-value determinations.
- *Design-Based Safe Harbor Checklists.* The agencies intend to issue safe harbor checklists that employer-sponsored plans can compare to plan coverage, based on data of a standard population from self-insured group health plans.
- *Actuarial Certification.* If the above methods are not applicable to an employer-sponsored plan (for example, a plan with nonstandard features such as limits on physician visits or inpatient hospital days), the plan will be able to make an MV determination through certification by an actuary who is a member of the American Academy of Actuaries.

The final regulations also provide that employer contributions to an HSA and amounts newly made available under integrated health reimbursement arrangements (HRAs) – specifically HRAs that may be used only for cost-sharing – will be taken into account in determining MV.

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