March 19, 2013

**Health Care Reform—Essential Health Benefits, Cost-Sharing Limits and Minimum Value**

On February 25, 2013, the Department of Health and Human Services (HHS) published a final regulation covering the essential health benefits (EHB), actuarial value and minimum value under the Patient Protection and Affordable Care Act (PPACA or ACA). HHS also published a fact sheet on the rule. Along with the final regulation, HHS, in conjunction with the Department of Labor (DOL) and the Internal Revenue Service (IRS) (collectively, the Departments), published a set of frequently asked questions (FAQs) related to limitations on deductibles and cost-sharing, and coverage of preventive services by group health plans under the ACA.

Starting January 1, 2014, non-grandfathered health insurance plans in the individual and small group market [including those in the health insurance exchanges (Exchanges)] will be required to provide coverage of benefits or services in 10 separate categories that reflect the scope of benefits covered by a typical employer plan. Qualified health plans (QHPs) offered through Exchanges will provide a benefits package that covers EHB and complies with certain cost-sharing limits and actuarial value requirements.

The EHB Rule also provides guidance about how employer-provided health plans, like those maintained by United Methodist annual conferences, can satisfy the ACA requirement that the plan cover a “minimum value” (MV), i.e., cover at least 60% of all claim costs by participants. HHS and IRS published an MV calculator, along with the rule for employers to use as an approved method for determining whether a plan provides minimum value.

The Departments also indicated in the EHB Rule and FAQ that the maximum deductibles for health plans under the ACA, explained below, do not apply to self-insured employer-provided group health plans, such as HealthFlex and many other annual conference plans. The Departments, however, stated that the cost-sharing limits for health plans under the ACA (the maximum out-of-pocket amounts for covered participants), also explained below, will apply to self-insured group health plans, like HealthFlex and other annual conference plans, beginning in 2014.

**Annual Limits**

The cost-sharing limits under the ACA include both an overall annual limit (an out-of-pocket maximum) and an annual deductible limit. The Departments have interpreted the ACA such that all insured health plans and group health plans, including self-funded plans like HealthFlex and other annual conference plans, must comply with the ACA’s annual limitation on out-of-pocket maximums. Conversely, the Departments interpreted the ACA so that only insured health plans from insurance companies in the individual and small group markets are subject to the ACA’s limits on deductibles. Self-insured plans, e.g., HealthFlex and many annual conference plans, will not be subject to the ACA’s deductible maximums. Grandfathered plans are not subject to either of the ACA’s limits on cost-sharing.
**Annual Deductible Limit:** Beginning in 2014, the annual deductible for a health plan in the individual or small group market may not exceed **$2,000 for self-only coverage** and **$4,000 for family coverage**. For plans using provider networks, an enrollee’s cost-sharing for out-of-network benefits does not count toward the annual deductible limit. HHS will increase the annual deductible limits annually. This annual deductible limit applies only in the fully-insured individual and small group markets. Thus, the limit does not apply to HealthFlex, other self-insured annual conference plans or fully-insured annual conference plans in the large group market (large group plans typically cover more than 50 employees).

**Out-of-Pocket Maximum:** Beginning January 1, 2014, the ACA places annual limits on total participant cost-sharing for EHBs. Once the limitation on cost-sharing (i.e., the out-of-pocket maximum) is reached for the year, the participant is not responsible for additional cost-sharing for the remainder of the year. The ACA’s out-of-pocket maximum applies to all non-grandfathered health plans and group health plans. This would include, for example, self-insured health plans and fully-insured health plans of any size in any market. The out-of-pocket maximums will apply to HealthFlex and self-insured annual conference plans.

Cost-sharing includes any expenditure required by or on behalf of an enrollee with respect to EHB, such as deductibles, co-payments, co-insurance and similar charges. It excludes premiums and spending for non-covered services. Furthermore, a participant’s cost-sharing for out-of-network services is not counted in the cost-sharing limit for plans using provider networks.

ACA’s cost-sharing limit is tied to the out-of-pocket maximum for health savings account (HSA)-compatible high-deductible health plans (HDHPs). There are separate limits for self-only coverage and family coverage (other than self-only). Because these limits are adjusted annually for cost-of-living increases, the 2014 out-of-pocket maximums for HDHP coverage are not currently available. However, for 2013, the HDHP out-of-pocket maximum cannot exceed $6,250 for self-only coverage and $12,500 for family coverage. The IRS will publish out-of-pocket maximum limits for 2014 in Spring 2013. For plan years after 2014, HHS will increase the cost-sharing limits similar to increases in the annual deductible limit.

**Transition Relief—Plans with Multiple Service Providers:** The FAQs address how the ACA’s out-of-pocket maximum applies to plans that utilize more than one service provider to administer benefits (e.g., a third-party administrator for major medical coverage and a separate pharmacy benefit manager). Separate plan service providers often impose different out-of-pocket-maximums and may utilize different methods for crediting participants’ expenses against the maximums. According to the FAQs, these processes will need to be coordinated to comply with the new annual out-of-pocket maximum, which may require new regular communications between separate plan service providers.

The following applies to only the first plan year beginning on or after January 1, 2014 (the 2014 calendar year for most annual conference plans). Where a group health plan utilizes more than one service provider to administer benefits that are subject to the annual out-of-pocket maximum, the annual limit will be satisfied if both of the following conditions are met:

- The plan complies with the out-of-pocket maximum with respect to its major medical coverage (excluding, for example, prescription drug coverage); and
- To the extent there is an out-of-pocket maximum on coverage that does not consist solely of major medical coverage, e.g., prescription drug coverage, this out-of-pocket maximum may not exceed the maximum dollar amount under ACA (to be defined in Spring 2013 for plan year 2014).

**Reminder:** Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, plans already are “prohibited from imposing an annual out-of-pocket maximum on mental health and substance abuse benefits.”
This one-year transition allows plans with separate out-of-pocket maximums to satisfy the limits for 2014 as long as none of the separate maximums exceed the dollar maximum. However, by 2015 these plans will need to have their separate claims administrators coordinated so that all benefits subject to the out-of-pocket maximums do not exceed a single out-of-pocket maximum.

**Essential Health Benefits**

The ACA requires non-grandfathered health plans in the individual and small group market (both within the health insurance exchanges and those in fully-insured markets outside the Exchanges) to cover 10 categories of essential health benefits. The EHB requirement is intended to ensure that consumers in these markets have adequate coverage and to improve competition among health plans by standardizing choices. Most of the EHBs are services already covered by most health plans, such as hospitalization or pharmaceuticals; however, some are not commonly covered, such as (re)habilitative services or pediatric oral and dental care. **Self-insured group health plans, like HealthFlex and many other annual conference health plans, are not subject directly to the EHB requirements.** Although these plans are not required to cover all EHBs, most plans typically do cover many EHBs. Nonetheless, the EHB Rule affects self-insured plans in indirect ways. For example, the self-insured group health plans are prohibited from imposing annual or lifetime limits on any EHBs that they do cover.

Under the ACA, EHBs must include the items and services within the following 10 categories:

1. Ambulatory patient services (i.e., outpatient care)
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
10. Pediatric services, including oral and vision care

EHBs do not include routine non-pediatric dental services or eye exams, non-medically necessary orthodontia, or long-term/custodial nursing home benefits.

Each state will identify a single EHB-benchmark plan—defined as the standardized set of EHBs that must be met by the Exchange plans—from the following four choices:

1. The largest health plan (as measured by enrollment) in any of the three largest small group insurance products (by enrollment) in the state’s small group market,
2. Any of the largest three employee health benefit plan options (by enrollment) offered and available to state employees,
3. Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options (by enrollment), or
4. The largest insured non-Medicaid health maintenance organization (HMO) operating in the state.

If a state does not make a selection, the default base-benchmark plan will be Option 1 above. **Appendix A** of the final regulation includes the list of EHB-benchmark plans for 2014 and 2015.
The EHB regulations prohibit discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions in the EHB definition process. The regulations also prohibit discrimination in EHBs on the basis of race, color, national origin, sex, gender identity or sexual orientation.

**Actuarial Value**

HHS also published an actuarial value calculator for determining the actuarial value (AV) of individual and small group health plans. The AV calculator will be used to determine the “metal level” (bronze, silver, gold or platinum) of non-grandfathered health plans in the individual or small group market. Recall that the ACA creates four tiers of health plans available for purchase through the Exchanges. Each tier is defined by its AV, or percentage a health plan pays of the total allowed costs of benefits.

- Bronze health plan has 60% AV.
- Silver health plan has 70% AV.
- Gold health plan has 80% AV.
- Platinum health plan has 90% AV.

The value may vary by plus or minus 2%. The purpose of establishing these “metal” levels is to help individuals compare health plans.

Employer contributions to health savings accounts (HSAs) and amounts made newly available under integrated health reimbursement arrangements (HRAs) that may only be used for cost-sharing (not premium payment) may be counted toward the plan’s AV, if known to the insurance company at the time a plan is purchased.

**Minimum Value**

Beginning in 2014, employer health plans must provide minimum value (MV), which is similar to AV. HHS and IRS published an MV calculator in proposed form. HHS also published its methodology for the MV calculator. Plan sponsors will be able to use the MV calculator to determine whether their plans provide at least 60% actuarial value (i.e., bronze-level coverage). If an employer health plan fails to meet this requirement, employees can opt out of the plan and, if they are eligible based on their income, receive a premium tax credit (PTC) through an Exchange. If employees do so, the employer may owe a penalty. **Note:** This penalty applies only to large employers (defined as 50 or more full-time equivalent employees).

As noted in the EHB Rule, a plan sponsor may avail itself of “an array of design-based safe-harbors published by HHS and the IRS in the form of checklists to determine whether the plan provides MV.” Alternatively, an employer health plan may seek certification by an actuary to determine minimum value if the plan contains non-standard features that do not fit well in the MV calculator or the safe harbor checklist. Employer contributions to HSAs and amounts made newly available under integrated HRAs may be counted toward the plan’s MV.

**Annual Conference Health Plan Considerations**

United Methodist annual conferences that are self-insured and those with fully-insured plans in the large group market (this should be nearly all annual conferences) will retain the flexibility to modify plan deductibles as they see fit, not subject to the ACA’s restrictive deductible maximums. However, the same annual conferences will have to ensure that their plans have cost-sharing maximums for participants (annual out-of-pocket limits) that do not exceed those established by the ACA (currently, $6,250 for self-only coverage and $12,500 for family coverage). Annual conferences may also now begin using the published...
minimum value calculator to determine whether the designs for their health plans for 2014 will satisfy the MV requirement under the ACA (or else use one of the other permitted safe harbor methods). For plan sponsors of HealthFlex, the General Board will manage these tasks.

The EHB rules should give annual conferences and local churches an idea of what the health plans on the Exchanges will look like. The state EHB-benchmark plan can also provide a good measuring stick for annual conferences to compare the robustness of their plans to those on the Exchanges.

Questions and Information

If you have questions or would like additional information, please send your inquiries to healthcarereform@gbophb.org. General information about health care reform is available from the federal government at www.healthcare.gov.

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