Essential Health Benefit Package, AV & MV under the Affordable Care Act

A main objective of the Affordable Care Act (ACA) is to expand accessibility of health insurance coverage to all Americans. ACA recognizes that the lack of access and affordable coverage is concentrated among the poor and the working poor families as well as self-employed and small businesses (defined as employers with less than 50 full-time employees). Through Health Insurance Exchanges (Exchanges), now known as Health Insurance Marketplaces (Marketplace), individuals and small businesses can shop for health insurance coverage and apply for and receive tax credits and cost subsidies when applicable. To this end, health plans and levels of coverage must be standardized in order to ease the consumer purchasing process and minimize confusion. On February 25, 2103, the Department of Health and Human Services (HHS) published final regulation related to Essential Health Benefits, Actuarial Value and Accreditation. [FR Vol. 78, no 37[1]]

Beginning with plan years starting on or after January 1, 2014, **all non-grandfathered health insurance coverage in the individual and small group markets** will cover essential health benefits (EHB), which include items and services in 10 statutory benefit categories (to be further expanded below). Further, non-grandfathered health insurance plans will meet specific actuarial values (AVs). These AVs, called ''metal levels,'' will assist consumers in comparing and selecting health plans by allowing a potential enrollee to compare the relative payment generosity of available plans. Taken together, EHB and AV will significantly increase consumers' abilities to compare and make informed choices about health plans.

Essential Health Benefit Package

ACA § 1301(a)(1)(B) directs all issuers of Qualified Health Plans (QHPs are plans offered through an Exchange) to cover the EHB package. The Public Health Service Act (PHS) § 2707(a) extends the coverage of the EHB package to issuers of **non-grandfathered individual and small group policies** irrespective of whether such issuers offer coverage through an Exchange. Under ACA § 1302(a), the EHB package includes coverage of EHB, cost-sharing limits and AV requirements.

Essential Health Benefits[2]

EHB must cover at least the following 10 general categories without annual or lifetime dollar limits:

- ambulatory patient services; emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services[3], including oral and vision care.

[1] http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

[2] The only exception permitted under ACA § 1302 is for QHPs to exclude coverage of the pediatric dental EHB if there is a stand-alone dental plan offered in the Exchange.

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HHS must periodically review the EHB and update the EHB as needed to address any gaps in access to care or advances in the relevant evidence base.

Cost Sharing Limits Under Group Health Plans

PHS § 2707(b) states that group health plans shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of ACA §1302(c). HHS interprets this as only applicable to plans and issuers in the small group market. The cost-sharing incurred under a health plan shall be subject to the dollar limits in effect under Internal Revenue Code (IRC) § 223(c)(2)(A)(ii), which are tied to the enrollee out-of-pocket limit for high deductible health plans. For 2014,[4] the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits must not exceed: [ACA §1302(c)(1)(A)]

- $6,350 for self-only and
- twice the amount of the self-only limit for family or $17,500

Additionally, for 2014, in the case of a health plan offered in the small group market, the deductible under the plan shall not exceed: [ACA §1302(c)(2)(A)]

- $2,000 in the case of a plan covering a single individual and
- $4,000 in the case of any other plan.

ACA § 1302(c)(2)(A) permits but does not require contributions to flexible spending arrangements (FSAs) to be taken into account when determining the deductible maximum. The final rule does not increase the deductible levels by the amount available under the FSA. Furthermore, in the case of a plan using a network of providers, cost-sharing paid by or on behalf of an enrollee for benefits provided outside of such network shall not count towards the annual limitation on cost-sharing or the annual limitation on deductibles. However, a QHP must (1) provide coverage for emergency department services provided out-of-network without imposing any requirement under the plan for prior authorization of services or any limitation on coverage for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from network providers and (2) apply the same cost sharing in the form of a copayment or coinsurance for emergency department services for an out-of-network provider as would apply to an in-network provider.

AV Requirement

AV is defined as the percentage paid by a health plan of the total allowed costs of benefits.[5] ACA § 1302(d)(2) describes the levels of coverage that § 1302(a)(3) includes in the EHB package. A *di minimis* variation of +/- 2 percentage points for all non-grandfathered plans is allowed.

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[3] services for individuals under the age of 19 years

[4] Internal Revenue Service issued Revenue Procedure 2013-25, http://www.irs.gov/pub/irs-drop/rp-13-25.pdf

[5] The "percentage of the total allowed costs of benefits" is defined as the anticipated covered medical spending for EHB coverage paid by a health plan for a standard population, computed in accordance with the health plan's cost sharing, divided by the total anticipated allowed charges for EHB coverage provided to the standard population, and expressed as a percentage.

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Here are the 4 "metal tiers" based on their respective AV level:

- 60 percent for a bronze plan
- 70 percent for a silver plan
- 80 percent for a gold plan, and
- 90 percent for a platinum plan.

AV Calculator

The Affordable Care Act directs issuers offering non-grandfathered health insurance coverage in the individual and small group markets, including QHPs, to ensure that plans meet a level of coverage as so specified in the AV Requirement section above. Each level of coverage corresponds to an AV calculated based on the cost-sharing features of the plan.

An issuer would use the AV Calculator[6] developed by HHS to determine the health plan's level of coverage. AV can be calculated based on the provision of the EHB to a standard population, and the AV Calculator must use one or more sets of national claims data reflecting plans of various levels of generosity as the underlying standard population. Although HHS anticipates that the vast majority of plans will be able to use the calculator in 2014 and beyond, no uniform calculator can accommodate the entire potential universe of plan designs. For plan designs not compatible with the calculator, such plans would need to submit documentation (to the appropriate entity: the state, HHS, the Exchange, or OPM) in the form of actuarial certification that they have complied with one of the two methods below and exclude out-of-network costs.

1. A health plan issuer is permitted to decide how to adjust the plan benefit design (for calculation purposes only) to fit the parameters of the calculator and then have a member of the American Academy of Actuaries certify that the methodology was fit to the parameters of the AV Calculator in accordance with generally accepted actuarial principles and methodologies.

2. A health plan may use the calculator for the plan design provisions that correspond to the parameters of the calculator and then have a member of the American Academy of Actuaries calculate appropriate adjustments to the AV as determined by the AV Calculator for plan design features that deviate substantially, in accordance with generally accepted actuarial principles and methodologies.

Recognizing that employer-provided, integrated HSAs and HRAs are generally the equivalent of first dollar coverage for any cost-sharing requirements encountered by the enrollee, the AV Calculator would include any current year HSA contributions or amounts newly made available under integrated HRAs for the current year as an input into the calculator that can be used to determine the AV of an employer-

[6] AV Calculator Methodology Final - http://www.cms.gov/CCIIO/Resources/Files/Downloads/av-calculator-methodology.pdf, AV Calculator: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/av-calculator-final.xlsm

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sponsored health benefit plan. Employer contributions must be made known to the issuer when the plan is purchased.

Minimum Value

IRC § 36B(c)(2)(C)(ii) [26 U.S.C. § 36B(c)(2)(C)(ii)] provides that an employer-sponsored plan provides minimum value (MV) if this percentage is no less than 60 percent. Otherwise, the applicable large employer may be subject to 4980H penalties if one or more eligible full-time employees are certified to have obtained a QHP through an Exchange and received tax credit and/or cost sharing benefits. Employer-sponsored, self-insured and insured large group plans do not need to cover every EHB category or conform their plans to an EHB benchmark that applies to QHPs. HHS finalizes the use of an MV Calculator[7] to determine the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage. The results provided by this MV Calculator ensure that the determination of whether a group health plan provides MV is made in compliance with the Affordable Care Act and regulatory standards. MV is based on the anticipated spending for a standard population.

MV = The anticipated covered medical spending for EHB coverage computed in accordance with the plan's cost-sharing ÷ The total anticipated allowed charges for EHB coverage provided to a standard population.

There are three methods for determining MV:

1. The MV Calculator produces an empirical estimate of the actual average spending by a wide range of consumers representative of those currently enrolled in self-insured, employer-sponsored plans.
2. An employer-sponsored plan would be able to use an array of **design-based safe-harbors** published by HHS and the Internal Revenue Service in the form of checklists to determine whether the plan provides MV.
3. **This option is only available** if an employer-sponsored plan contains non-standard features that are not suitable for the use of the calculator and do not fit the safe harbor checklists: MV to be determined through certification by an actuary without the use of the MV Calculator. The actuary would make this determination based on the plan's benefits and coverage data and the standard population, utilization, and pricing tables available for purposes of the valuation of employer-sponsored plans.

[7] MV Calculator Methodology Final - http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-methodology.pdf MV Calculator: http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

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Designed-Based Safe Harbors

Certain safe harbor plan designs that satisfy MV will be specified in addtional future guidance under section 36B or 4980H. It is anticipated that the guidance will provide that the safe harbors are examples of plan designs that clearly would satisfy the 60 percent threshold if measured using the MV Calculator.

Under IRS proposed regulation published on May 3, 2013 [FR Vol 78 No 86[8]], plan designs meeting the following specifications are proposed as safe harbors for determining MV if the plans cover all of the benefits included in the MV Calculator:

1. a plan with a $3,500 integrated medical and drug deductible, 80% plan cost-sharing, and a $6,000 maximum out-of-pocket limit for employee cost-sharing;
2. a plan with a $4,500 integrated medical and drug deductible, 70% plan cost-sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to an HSA; and
3. a plan with a $3,500 medical deductible, $0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a $6,400 maximum out-of-pocket limit, and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75% coinsurance for specialty drugs.

HSA, HRA and Wellness Programs Affect MV

Health Savings Account - All amounts contributed by an employer for the current plan year to an HSA are taken into account in determining the plan's share of costs for purposes of MV and are treated as amounts available for first dollar coverage.

Health reimbursement Arrangement - Amounts newly made available under an HRA that is integrated with an eligible employer sponsored plan for the current plan year count for purposes of MV in the same manner if the amounts may be used only for cost-sharing and may not be used to pay insurance premiums.

Non-Discriminatory Wellness program - The IRS proposed regulation states that a plan's share of costs for MV purposes is determined without regard to reduced cost-sharing available under a nondiscriminatory wellness program. However, for nondiscriminatory wellness programs designed to prevent or reduce tobacco use, MV may be calculated assuming that every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use. This unexpected turn of events has a chilling effect on establishing employer-based wellness programs.

[8] http://www.gpo.gov/fdsys/pkg/FR-2013-05-03/pdf/2013-10463.pdf

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AV vs MV Calculator

The AV Calculator was designed to reflect a standard population. Because it represents the individual and small group markets, the AV Calculator was designed to include data that is reflective of these anticipated populations. Whereas, the MV Calculator is intended to test whether an employer-sponsored group health plan – which is not in the individual or small group insurance markets - provides minimum value and therefore determine if an employee is eligible for a premium tax credit. The MV Calculator has similar functionality to the AV Calculator but is based on claims data that better reflects typical employer-sponsored plans.

Conclusion

For a non-applicable large employer interested in a non-grandfathered small group policy or an individual interested in coverage through an Exchange, beginning in 2014, all QHPs will offer EHBs. Through the standardization of the coverage tiers and the application of actuarial value standards, the plans will be subject to cost-sharing limits and a di minimis variation of +/- 2 percentage points. Small employers and individuals are expected to be able to compare health plans and costs in a more straight forward manner.

For applicable large employers, none of the EHB Package applies. Instead, the health insurance offered must meet the MV and affordability guidelines established in order for an employer to not be subject to the penalties assessable under 4980H (a) and (b).

As 2014 approaches, more regulatory guidance and final rules will be issued to assist employers and individuals to properly comply and to create the processes and procedures to adhere with ACA and related regulations.

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