Final Rule Limits Out-Of-Pocket Maximums; Addresses Minimum Value and Essential Health Benefits

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Employers received an unwelcome answer from the Department of Health and Human Services (HHS) when the agency issued a final rule providing that out-of-pocket (OOP) limits up to the health savings account (HSA) OOP limit will apply to all non-grandfathered group health plans in the self-insured and large group markets. The final rule also sets forth the methods for employer-sponsored self-insured group health plans to determine whether their plans provide minimum value (MV). However, the new rule provides little clarification on the determination of essential health benefits (EHBs) for purposes of complying with the prohibition on annual and lifetime dollar limits on EHBs. The final rule, implemented by the Patient Protection and Affordable Care Act (Affordable Care Act), was published in the Federal Register on February 25, 2013 and becomes effective on April 26, 2013.

This Aon Hewitt bulletin discusses the following parts of the final rule released by HHS:

- Application of the OOP limit to self-insured and large group health plans;
- Calculation of MV for self-insured and fully insured plans in the large group market; and
- Determining EHBs for purposes of the prohibition on annual and lifetime dollar limits.

Annual Limit on OOP Maximums

The preamble to the final rule states that the Departments of HHS, Labor, and Treasury (the agencies) intend to apply the annual limit on OOP maximums to non-grandfathered self-insured and large group health plans. Beginning in 2014, all non-grandfathered self-insured or large group health plans will have to limit annual OOP maximums to the HSA limits associated with high-deductible health plans that are set by the Internal Revenue Service (IRS) each year. A transition rule in 2014 to address operational and timing issues was also released February 20, 2013.

Calculation of Minimum Value

Beginning in 2014, if an employer offers a plan to its full-time employees that does not meet MV, and an employee receives a premium tax credit or cost-sharing reduction to purchase coverage through an Exchange (marketplace), an employer will be liable for a penalty equal to 1/12 of $3,000 times the number of employees who receive a tax credit per month.

To meet the MV requirement, the percentage of the total allowed costs of benefits provided under the plan must be no less than 60%. The final rule provides that an employer can use one of three methodologies to determine MV: a MV calculator, a safe harbor checklist, or an actuarial certification based on a standard population based on data from self-insured health plans.
MV Calculator

The MV calculator allows an employer-sponsored plan to enter information about the plan’s cost sharing to produce an MV figure for the plan. The calculator will accommodate both grandfathered and non-grandfathered plans.

For plans that use the MV calculator and offer an EHB outside of the parameters of the MV calculator, the plan may seek an actuarial certification to determine the value of that benefit and adjust the result derived from the MV calculator to reflect that value. This provision is designed to consider the value of benefits that are among the EHB options but not necessarily in a state benchmark because there is no EHB standard for employer-sponsored self-insured plans or insured large group health plans. To calculate MV, employer-sponsored plans can take into account any benefits covered by the plan that are also covered in any one of the EHB-benchmark plan options in any state.

Safe Harbor Checklist

HHS and IRS will publish an array of design-based safe harbor checklists that an employer-sponsored plan can use to determine whether the plan provides MV. Each safe harbor checklist will describe the cost-sharing attributes of a plan that apply to four core categories of benefits and services: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services.

Actuarial Certification

If the employer-sponsored plan contains non-standard features that are not suitable for either the MV calculator or the safe harbor checklists, the plan may seek an actuarial certification. The actuary will make the determination based on the plan’s benefits and coverage data and the standard population, utilization, and pricing tables available for employer-sponsored plans. Guidance will be issued that will provide more detail on the actuarial analysis. This option is only available when one of the other methodologies is not applicable to the employer-sponsored plan.

Employer HSA and HRA Contributions

The final rule allows current year employer contributions to an HSA and amounts newly made available under integrated health reimbursement arrangements (HRAs) (HRAs that may be used only for cost sharing) to be taken into account when determining MV. These contributions are treated as covered “first dollar” spending for covered services. For example, a $1,000 HSA contribution is treated as if a plan with a $1,000 deductible had no deductible.

No De Minimis Variation Allowed

Despite requests to do so, HHS will not allow a +/- 2% variation in the calculation of MV as is allowed in the calculation of actuarial value for purposes of a qualified health plan in an Exchange (marketplace).
Determining EHBs for Purposes of Annual and Lifetime Dollar Limits

The Affordable Care Act prohibits self-insured and large group health plans, including grandfathered group health plans from imposing annual and lifetime dollar limits on any EHB. However, there is no clear definition of what benefits are EHBs since HHS allows each state to choose a benchmark plan to serve as the standard for each state. The preamble to the final rule states that the agencies will consider a self-insured, large group, or grandfathered group health plan to have used a permissible definition of EHBs for purposes of the annual and lifetime dollar limitations if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all 10 categories of EHBs). The agencies intend to work with plans that make a good faith effort to apply an authorized definition of EHBs to ensure there are no annual or lifetime dollar limits on EHBs.

Resources


The MV calculator with accompanying continuance tables and the MV methodology are available at: http://cciio.cms.gov/resources/regulations/index.html#pm

Aon Hewitt's Regulatory Guidance Under the Affordable Care Act page, which provides links to Aon Hewitt bulletins on Affordable Care Act guidance and regulations, is available at: http://www.aon.com/human-capital-consulting/thought-leadership/leg_updates/healthcare/index_regulatory_guidance_affordable_care.jsp
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