HUMAN CAPITAL PRACTICE

Willis ALERT

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HHS ISSUES FINAL RULES ON DETERMINATION OF MINIMUM VALUE

Last November, the Internal Revenue Service (IRS) announced in **Notice 2014-69** that a plan that achieved a 60% or higher actuarial value would nonetheless not be a minimum value (MV) option if it did not provide "substantial" hospitalization and physician services. In **final regulations 45 CFR 156.145(a)** issued February 20, 2015, the Department of Health and Human Services (HHS) adopted rules as identified in the IRS notice, by revising paragraph (a) introductory text to read:

> **§156.145 Determination of minimum value.** (a) Acceptable methods for determining MV. An employer-sponsored plan provides minimum value (MV) only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.

These final regulations are effective April 28, 2015.

BACKGROUND

To avoid both employer-shared responsibility penalty taxes, both Internal Revenue Code (IRC) §§ 4980H(a) (~$2,000/year) and (b) (~$3,000/year) penalty taxes, an employer must offer at least one health option that is "affordable," "minimum essential coverage" of "minimum value."

"Minimum essential coverage," or MEC, is essentially any employer-sponsored plan that does not consist of excepted benefits (e.g., most dental or vision coverage and most health flexible spending accounts) and that provides no less than the 63 no-cost-sharing preventive services required by the Patient Protection and Affordable Care Act (PPACA) for non-grandfathered plans, plus routine medical expenses for clinical trials. However, MEC is not MV unless the coverage also has an actuarial value of 60% – using the **calculator** supplied by the government.

"Minimum value" has now been expanded beyond a 60% actuarial value also to include "substantial inpatient hospital services and physician services." Again, for an employer to be certain that it will avoid ***all*** employer-shared responsibility penalty taxes, the employer must offer at least one health plan that is "affordable," "minimum essential coverage" of "minimum value" to **all** "full-time" employees and their "dependents."

In Notice 2014-69 a plan that achieved a 60% or higher actuarial value would nonetheless not be a minimum value (MV) option if it did not provide "substantial" hospitalization and physician services.

DEFINING SUBSTANTIAL

HHS did not define "substantial" but indicated that it would provide additional guidance "as circumstances warrant."

In the preamble, HHS noted that:

> ...we have concluded that the quantitative test for MV is not exclusive...to provide MV, an employer-sponsored plan not only must meet the quantitative standard of the actuarial value of benefits, but also must provide a benefit package that meets a minimum standard of benefits. Specifically...that, to satisfy MV, an employer plan must provide substantial coverage of both inpatient hospital services and physician services...
>
> ...We are not requiring that large employer or self-insured employer group health plans provide all EHB [essential health benefits] as defined under section 1302 of the Affordable Care Act. Rather, we are only requiring that, to provide MV, employer-sponsored plans provide substantial coverage of the two types of benefits that we believe were envisioned for health plan coverage meeting the MV standard. We have concluded that plans that omit these types of coverage fail to meet universally accepted minimum standards of value expected from, and inherent in the nature of, any arrangement that can reasonably be called a health plan intended to provide the primary health coverage for employees. **Consistent with Notice 2014-69, we are finalizing our proposal that these changes to our regulations on MV will apply to employer-sponsored plans, including plans that are in the middle of a plan year, immediately on the effective date of the final regulations.**

So, uncertainty remains concerning "substantial" coverage. Commenters had asked HHS to establish a clear standard, and even suggested specifics, that the guidance:

- Be based on a survey of employer-sponsored plans
- Use the Federal Employee Health Benefit Plan as the benchmark

  OR
- Define "substantial" as four days of hospitalization, or perhaps multiple periods of hospitalization not to exceed four days each.

HHS did not implement these suggestions. It noted:

> ...A plan that excludes substantial coverage for inpatient hospital and physician services is not a health plan in any meaningful sense and is contrary to the purpose of the MV requirement to ensure that an employer-sponsored plan, while not required to cover all EHB, nonetheless must offer coverage with minimum value at least roughly comparable to that of a bronze plan offered on an Exchange. For these reasons, the Secretary has concluded that [Congress's decision to determine minimum value as a percentage of Essential Health Benefits]...reflect[s] a statutory design to provide basic minimum standards for health benefits coverage through the MV requirement, without requiring large group market plans and self-insured plans to meet all EHB standards...

HHS finalized the regulations, noting: "We intend to provide further clarity on the requirement to provide 'substantial coverage,' as circumstances warrant." HHS also rejected claims that a decision to include substantial hospitalization services and physician services benefits will trigger widespread Cadillac tax assessments.

WHAT'S AN EMPLOYER TO DO?

"Substantial" is likely to include something more than a few days of hospitalization and something less than all hospitalization. Since HHS rejected defining "substantial" as four days of hospitalization (or any specific number of days), such a benefit is likely insufficient.

If an employer that offers a minimum value plan (MVP) without hospitalization wants to continue that option (whether or not the transitional rule applies, as discussed in Willis's November 4, 2014 News Flash, "IRS Issues Warning to Group Health Plans Not Covering Hospitalization or Physician Services"), the employer has two likely choices:

- Change the design to increase the deductible and include hospitalization on much the same basis as any other expense, such as a 2015 design with an embedded deductible of perhaps $6,000 or more, with coinsurance of 90% or more after satisfying the deductible, up to the statutory out-of-pocket expense maximum of $6,600/$13,200

  OR
- Add a "substantial" hospital benefit to the existing design, capping the number of days of hospitalization benefits and raising the deductible proportionately

There is no guidance on how an employer might determine the maximum number of days of hospitalization benefits. While somewhat arbitrary, Congress has effectively asserted that Medicare Part A qualifies as "substantial" hospitalization coverage with 2015 cost sharing of:

- $ 0 for the first 60 days,
- $315 for days 60 – 90
- $630 for days 91 and beyond

Note that because Medicare Part A does not have any maximum out-of-pocket provision, adding a "substantial" hospitalization benefit to the existing MVP design might incorporate a maximum number of days of hospitalization, say 60, while also raising the deductible proportionately to keep the value close to 60%. Generally speaking, most hospital stays are less than a week in duration, few individuals are admitted more than once or twice a year, and despite that, the costs of even one hospital stay of seven days will always satisfy the out-of-pocket expense maximum in a non-grandfathered health plan. So, while the selection of a numeric cap on benefit days in excess of 10 per person will only impact a minority of individuals, such a cap would clearly be inconsistent with the HHS position on health reform's goal that an employer's offer of MV coverage should be "coverage with minimum value at least roughly comparable to that of a bronze plan offered on an Exchange" (public exchange coverage does not have any numeric cap on days of hospitalization benefits).

Finally, linking a non-hospitalization MVP design with a "dollar per day" hospitalization benefit may not be permitted. That is, a "dollar per day" hospital benefit likely doesn't satisfy health reform's annual dollar limit provisions – since the regulators may look at such a limit as an annual or lifetime dollar limit (e.g., $100 per day for 100 days = $10,000, $100 per day for 365 days = $36,500). Certainly, annual dollar limits are permitted if the coverage is an "excepted benefit." A "dollar-per-day" hospitalization benefit only qualifies as an excepted benefit if it meets the requirements of IRC §9832(c)(3)(B): "...benefits not subject to requirements if offered as independent, non-coordinated benefits...hospital indemnity or other fixed indemnity insurance." However, when a "dollar per day" hospitalization benefit is combined with a non-hospitalization MVP, regulators may look at such a combination as a single option – that the hospitalization coverage is no longer offered "independently."

Again, what's an employer to do? If you adopted a non-hospitalization "minimum value" plan (MVP) option, it suggests that:

- You may have a goal of avoiding all of the employer-shared responsibility penalty taxes
- You did not want, or could not afford, to offer hospitalization benefits
- If you have to offer hospitalization benefits in your minimum value plan, you would prefer that no one enroll

In other words, if you had wanted to offer such benefits, you would have already done so. If that accurately reflects your strategy, you may want to consider the alternative of a bare minimum value plan (bMVP) – check with your Willis Client Advocate® for more information.

Between now and the April effective date, Willis's National Legal and Research Group will reach out to the agencies through our national benefits trade associations to seek clarification of the definition of "substantial" and will provide additional updates concerning this evolving standard.

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