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The Essentials: ACA Terminology Related to Essential Health Benefits, Minimum Essential Coverage and Minimum Value

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The Patient Protection and Affordable Care Act ("ACA") utilizes many new – and often still undefined – terms in implementing health care reform. Some of these terms sound quite similar to one another, yet in practice they have very different meanings. This memorandum addresses three such terms – "essential health benefits," "minimum essential coverage," and "minimum value" – each of which are or will be very important to employers in understanding their obligations under the ACA. Attached to this memorandum is a chart addressing the application of each of these terms to different types of employer-sponsored coverage.

- ***Essential Health Benefits Are Subject to Restrictions on Lifetime and Annual Dollar Limitations.*** The ACA added new section 2711 to the Public Health Service Act ("PHSA"). PHSA section 2711 establishes certain prohibitions on lifetime and annual limits on the dollar value of essential health benefits. Starting with plan years beginning on or after September 23, 2010 (and subject to the transition relief for annual limits discussed below), in general, neither plans nor issuers may establish or maintain lifetime or annual limits on the dollar amount of essential health benefits for any individual. These restrictions are generally applicable only to essential health benefits offered as part of a group health plan or individual insurance coverage, regardless of grandfathered status (although grandfathered individual health coverage is not subject to otherwise applicable restrictions on annual limits for plan years beginning before January 1, 2014). The ACA provides transition relief prior to January 1, 2014, during which time a plan or issuer may impose restricted annual dollar limits on essential health benefits; these limits began at $750,000 in the first year (for plan or policy years that began on or after September 23, 2010 but before September 23, 2011), and then rose to $1.25 million for the next such year, and are planned to top out at $2 million for the final such year of transition relief.

  As set forth in the attached chart, these new restrictions apply only to certain types of health plans and policies (including certain medical savings accounts), and only to essential health benefits. Thus, a plan sponsor may still impose lifetime and/or annual dollar limits on all other benefits, i.e., non-essential health benefits. Additionally, a plan sponsor may impose other quantitative, non-dollar limits on both essential health benefits and non-essential health benefits.

  For purposes of the restrictions on lifetime and annual dollar limitations, the term "essential health benefits" has the same meaning given to it for purposes of ACA section 1302. As discussed in more detail below, the term has not yet been formally defined for purposes of ACA section 1302 (however, ACA section 1302 does list ten broad, general types of benefits that must be considered to be essential health benefits). In this regard, interim final regulations issued with respect to PHSA section 2711 state that plans are permitted to use a good faith effort to comply with a reasonable interpretation of the term for plan years beginning before final regulations defining the term are issued ("Good Faith Standard"). Thus, until final regulations are issued (or until guidance specifying otherwise is issued), it

seems that plans may rely on the Good Faith Standard to determine whether they cover essential health benefits subject to the PHSA section 2711 restrictions on lifetime and annual dollar limitations.

> **Example:** Employer A sponsors a self-funded major medical plan that provides coverage for, among others, pediatric surgical services (including oral and vision care) and adult vision care. Employer A uses a good faith reasonable interpretation as permitted under applicable regulations to classify the pediatric surgical services as an essential health benefit and the adult vision care as not an essential health benefit. Accordingly, Employer A is limited in its ability to impose annual and lifetime dollar limits with respect to the pediatric surgical services, but is not so limited with respect to the adult vision benefits. Employer A remains able to impose other quantitative non-dollar limits on essential and non-essential health benefits, and thus can impose such limits on the pediatric surgical services and/or the adult vision benefits.

- ***Certain Plans Must Cover Essential Health Benefits to Qualify as Minimum Essential Coverage.*** A similar-sounding, albeit very different, term is "minimum essential coverage." This term is to be distinguished from the term "essential health benefits" and is merely a descriptor for those types of coverages that qualify for purposes of the individual and employer mandates, which take effect beginning in 2014.

  Beginning in 2014, in order to comply with the employer and individual mandates set forth in the ACA, an employer generally must provide, and an individual must enroll in, minimum essential coverage. In order to qualify as minimum essential coverage, certain types of plans will need to, in part, provide coverage for an enumerated list of essential health benefits (see attached chart).

  The list of what constitutes an essential health benefit for this purpose is the same list that applies for purposes of applying the lifetime and annual dollar limits referenced above, i.e., that as governed by ACA section 1302. Notably, however, whereas almost all plans are subject to the restrictions on the use of annual and lifetime dollar limits with respect to essential health benefits (remember, such limits can always be applied to non-essential health benefits), generally only individual and small group insurance needs to provide for the full suite of essential health benefits. Hence, as was confirmed in recent Treasury Department regulations, self-funded plans, in contrast to insured policies, will remain free to pick and choose whether to provide coverage for a given essential health benefit. Note, however, that if the self-funded plan does provide for such coverage, it will need to comply with the restrictions on the use of annual and lifetime dollar limits imposed by PHSA section 2711.

> **Example:** Issuer B underwrites an insured small group health plan. In order to qualify as "minimum essential coverage," the policy must provide coverage for the full suite of enumerated essential health benefits. In contrast, Employer C, who sponsors a self-funded (or insured large group) plan, is not required to provide

coverage for the full suite of enumerated essential health benefits. Employer C is permitted to elect to provide coverage for none, some or all essential health benefits (subject to rules regarding "first-dollar preventive care"). Notably, Employer C, if he chooses to provide some or all essential health benefits, must continue to comply with the restrictions on the application of annual and lifetime dollar limits to those essential health benefits offered under the plan.

- ***Although the Enumerated List of Essential Health Benefits Remains Unknown, HHS Recently Issued a Bulletin that Provides Insight into Its Intended Regulatory Approach.*** As noted above, a detailed enumerated list (apart from the ten broad, general categories listed under ACA section 1302(b)) of essential health benefits has not yet been formally defined for purposes of ACA section 1302. Very recently, however, the Department of Health and Human Services ("HHS") issued a pre-regulatory bulletin ("Bulletin") that begins to provide insight as to the regulatory approach that may be used to define the suite of essential health benefits for purposes of determining whether certain insured coverage qualifies as minimum essential coverage.

  The Bulletin states HHS's intention to permit each state to define essential health benefits for coverage offered in such state pursuant to a benchmark plan selected by the state. The benefits and services included in the selected benchmark plan would be the required essential health benefits for that state.

  The Bulletin is very helpful for health issuers who seek to begin to understand their obligations in connection with providing insured minimum essential coverage. The Bulletin, however, could result in some confusion for sponsors of self-funded plans. Even though self-funded plans are not required to provide the enumerated suite of essential health benefits in order to qualify as minimum essential coverage, to the extent that a plan provides coverage for an essential health benefit, such benefit, as noted above, cannot be subject to certain annual and lifetime dollar limits. Accordingly, some sponsors and related parties have become concerned that the Bulletin could be read to indicate that sponsors of self-funded plans may need to look to the definitions established by one or more states when seeking to comply with the rules regarding the use of annual and lifetime dollar limits. Certainly, such a rule would be incredibly cumbersome and expensive to administer, if not nearly impossible.

  In issuing the Bulletin, it may well be that HHS did not intend to suggest that sponsors of self-funded and large group plans could no longer rely on their existing good faith interpretations of what constitutes an essential health benefit for purposes of complying with the restrictions on the use of annual and lifetime dollar limits. Indeed, given that the Good Faith Standard was enumerated in regulations jointly promulgated by three agencies (HHS, in conjunction with the Treasury Department and the Department of Labor), it is not clear that HHS would in any case have the authority to unilaterally alter this rule (and in sub-regulatory guidance, no less.) Trade associations, including the American Benefits Council, have submitted written comments requesting that HHS confirm that plan sponsors may continue to rely on their good faith interpretations for purposes of new PHSA section 2711 unless and until formal guidance to the contrary is issued. We are optimistic that such

guidance will be forthcoming.

- ***Although Self-Funded Plans Do Not Need to Provide the Suite of Essential Health Benefits, They Will Be Required to Provide "Minimum Value."*** Although self-funded plans will be excepted from having to provide the full suite of enumerated essential health benefits in 2014 and beyond, they will be required to provide "minimum value" if the employer plan sponsor wishes to avoid a penalty pursuant to the employer mandate provisions of new section 4980H of the Internal Revenue Code ("IRC") (see attached chart). Insured group health coverage also must provide minimum value (in addition to the full suite of enumerated essential benefits). However, issuers of individual policies need not provide minimum value.

  The term "minimum value" is to be distinguished from the term "minimum essential coverage." Whereas the term "minimum essential coverage" refers, in part, to the provision of the enumerated suite of essential health benefits, new IRC section 36B provides that coverage must provide minimum value in order to constitute minimum essential coverage. A plan is viewed as providing minimum value only if the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs. Although the express statutory language appears to provide that employers are not subject to specific benefit mandates so long as the plan's share of total allowed costs is at least 60%, it is our understanding that the agencies are considering the issuance of future rules that would impose a certain minimum value test on employer-sponsored plans (subject to a transition period). Employer groups such as the American Benefits Council are working hard to convey the message to regulators that they should not go beyond the express statutory language when issuing administrative guidance interpreting the term "minimum value." Only time will tell whether the regulators take heed, of course.

> **Example:** Employer D sponsors a self-funded plan and, as a result, is not required to provide coverage for the full suite of enumerated "essential health benefits" (see discussion and example above). However, to the extent that Employer D seeks to avoid a penalty for violation of the employer mandate per new IRC section 4980H, employer A will need to ensure that its plan provides "minimum value." (As noted above, what will constitute "minimum value" remains unclear.) Issuer E, who underwrites individual insurance, is not required to provide "minimum value."

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APPLICATION OF THE ACA'S[1] RULES REGARDING ESSENTIAL HEALTH BENEFITS (EHBS)

	Do Restrictions on Annual and Lifetime Dollar Limits Apply?		Must the Plan Provide Coverage for Mandated EHBs, i.e., the Essential Health Benefits Package?[2]	Must the Plan Provide "Minimum Value"?
	To Non-EHBs (to the extent provided)	To EHBs (to the extent provided)		
Medical Savings Accounts (where offered as stand-alone coverage)				
Health Flexible Spending Arrangements (FSAs)	No	No	No	No
Health Reimbursement Arrangements (HRAs)	No	Yes (unless subject to waiver)	No (unless insured, then TBD)	Appears Yes, if employer-provided (but TBD)
Health Savings Accounts (HSAs)[3]	No	No	No	No
Health Plans				
HIPAA-Excepted The term generally includes: ▪ Accident and disability ▪ Stand-alone dental and vision[4] ▪ Specified disease ▪ Hospital or other fixed indemnity ▪ Medicare supplemental The term generally does not include: ▪ EAPs (to the extent they are group health plans) ▪ Mini-med plans (unless otherwise HIPAA-excepted) ▪ Medicare Advantage	No	No	No	No
Self-Funded Health Plan (Grandfathered OR Non-Grandfathered)	No	Yes (unless subject to waiver)	No	Yes, if employer-provided
Small Group Policy	No	Yes (unless subject to waiver)	Yes, unless grandfathered	Yes, if employer-provided
Large Group Policy	No	Yes (unless subject to waiver)	No	Yes, if employer-provided
Individual Insurance Policy	No	Yes (unless subject to waiver)	Yes, unless grandfathered	No

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

[2] ACA § 1311(d); Public Health Service Act § 2707.

[3] Note that the underlying high-deductible health plan would be treated like major medical coverage.

[4] Per 29 C.F.R § 2590.732(c)(3), limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are considered to be "excepted benefits" if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan.

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