Group Health Plans that Fail to Cover In-Patient Hospitalization Services

Notice 2014-69

I. PURPOSE AND OVERVIEW

The Department of Health and Human Services (HHS) and the Department of the Treasury (including the Internal Revenue Service) (collectively, the Departments) have become aware that certain group health plan benefit designs that do not provide coverage for in-patient hospitalization services are being promoted to employers. A plan that fails to provide substantial coverage for these services would fail to offer fundamental benefits that are nearly universally covered, and historically have been considered integral to coverage, under typical employer-sponsored group health plans. Promoters of these plans contend that the plans satisfy minimum value within the meaning of the Affordable Care Act (including section 36B(c)(2)(C)(ii)of the Internal Revenue Code (Code) and final HHS regulations under section1302(d)(2)(C) of the Affordable Care Act (referred to in this notice as minimum value or MV)), as determined through use of the on-line MV Calculator referred to in final HHS regulations and proposed Treasury regulations.

Questions have been raised as to whether plans that fail to provide substantial coverage for in-patient hospitalization services should satisfy the requirements for providing minimum value. Concerns have been raised as to whether the continuance tables underlying the MV Calculator (and thus the MV Calculator) produce valid actuarial results for unconventional plan designs that exclude substantial coverage for in-patient hospitalization services. These concerns include that the standard population and other underlying assumptions used in developing the MV Calculator and associated continuance tables are based on typical self-insured employer-sponsored plans, essentially all of which historically have included coverage for these services, and that designing a plan to exclude such coverage could substantially affect the composition of the population covered by discouraging enrollment by employees who have, or anticipate that they might have, significant health issues. It has been suggested that these and other effects resulting from excluding substantial coverage of in-patient hospitalization services may not be adequately taken into account by the MV Calculator and its underlying continuance tables. Similar concerns have been raised regarding the possibility of using the MV calculator to demonstrate that an unconventional plan design that excludes substantial coverage of physician services provides minimum value.

The Departments believe that plans that fail to provide substantial coverage for in-patient hospitalization services or for physician services (or for both) (referred to in this notice as Non-Hospital/Non-Physician Services Plans) do not provide the minimum value intended by the minimum value requirement and will shortly propose regulations to this effect with a view to being in a position to finalize such regulations during 2015 and make them applicable upon finalization. Accordingly, employers should consider the consequences of the inability to rely solely on the MV Calculator (or any actuarial

certification or valuation) to demonstrate that a Non-Hospital/Non-Physician Services Plan provides minimum value for any portion of any taxable year ending on or after January 1, 2015, that follows finalization of such regulations. However, solely in the case of an employer that has entered into a binding written commitment to adopt, or has begun enrolling employees in, a Non-Hospital/Non-Physician Services Plan prior to November 4, 2014 based on the employer's reliance on the results of use of the MV Calculator (a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan), the Departments anticipate that final regulations, when issued, will not be applicable for purposes of Code section 4980H with respect to the plan before the end of the plan year (as in effect under the terms of the plan on November 3, 2014) if that plan year begins no later than March 1, 2015.

Pending issuance of final regulations, an employee will not be required to treat a Non-Hospital/Non-Physician Services Plan as providing minimum value for purposes of an employee's eligibility for a premium tax credit under Code section 36B, regardless of whether the plan is a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan.

II. BACKGROUND

An employee or family member who is offered coverage under an eligible employer-sponsored plan that offers affordable MV coverage for the employee may not receive premium tax credit assistance under Code section 36B for coverage in a qualified health plan. An applicable large employer (as defined in Code section 4980H(c)(2)) may be liable for a section 4980H assessable payment if one or more of its full-time employees receives a premium tax credit.

Under Code section 36B(c)(2)(C)(ii), a plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of the costs. Section 1302(d)(2)(C) of the Affordable Care Act provides that in determining the percentage of the total allowed costs of benefits provided by a group health plan or health insurance coverage under the Code, as well as under the Public Health Service Act (PHSA), regulations promulgated by the Secretary of HHS under section 1302(d)(2), addressing actuarial value, apply.

HHS published final regulations under section 1302(d)(2) on February 25, 2013 (78 FR 12834), effective on April 26, 2013. For plans required to cover the essential health benefits (EHB), the HHS regulations define the percentage of the total allowed costs of benefits as (1) the anticipated covered medical spending for EHB (as defined in 45 CFR 156.110(a)) paid by a health plan for a standard population, (2) computed in accordance with the plan's cost-sharing, and (3) divided by the total anticipated allowed charges for EHB coverage provided to a standard population. 45 CFR 156.20.

As stated in the preamble to the HHS regulations (see 78 FR 12833), employer-sponsored group health plans are not required to offer EHBs unless they are insured health plans offered in the small group market subject to section 2707(a) of the PHSA.

The preamble also states that MV is measured based on the provision of EHBs to a standard population based on typical self-insured group health plans and that, in determining MV, plans may take into account those benefits covered by the employer that are covered in any one of the state EHB-benchmark plans. See 45 CFR 156.145(b).

Proposed regulations under Code section 36B on MV published by Treasury and the IRS on May 3, 2013 (78 FR 25909), apply these rules in defining the standard population for MV purposes and the MV percentage. The proposed Code section 36B regulations provide that the MV percentage is determined by dividing the plan's anticipated spending (based on the plan's cost-sharing) for EHB under any one state benchmark plan by the total cost of EHBs for the standard population and converting the result to a percentage. Proposed 26 CFR 1.36B-6(c). Neither the final HHS regulations nor the proposed Code section 36B regulations require employer-sponsored self-insured and insured large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to individual and small group market plans.

The HHS regulations allow MV to be determined using an MV Calculator (available at http://cciio.cms.gov/resources/regulations/index.html) or a safe harbor established by HHS and the IRS. Under the regulations, plans with "nonstandard" features that are incompatible with the MV Calculator or a safe harbor may determine MV through an actuarial certification from a member of the American Academy of Actuaries. A plan in the small group market provides MV if it meets the requirements for any of the levels of metal coverage defined at 45 CFR 156.140(b) (bronze, silver, gold, or platinum).

The proposed Code section 36B regulations require plans to determine MV by using either a safe harbor or the MV Calculator. Employers using the MV Calculator may, however, supplement the MV Calculator by obtaining actuarial valuation of a plan's nonstandard features.

III. INTENDED APPROACH

A. Proposed Amendments to Regulations Relating to Minimum Value

HHS intends to promptly propose amending 45 CFR 156.145 to provide that a plan will not provide minimum value if it excludes substantial coverage for in-patient hospitalization services or physician services (or both). Treasury and the IRS intend to issue proposed regulations that apply these proposed HHS regulations under Code section 36B. Accordingly, under the HHS and Treasury regulations, an employer will not be permitted to use the MV Calculator (or any actuarial certification or valuation) to demonstrate that a Non-Hospital/Non-Physician Services Plan provides minimum value.

It is anticipated that the proposed changes to regulations will be finalized in 2015 and will apply to plans other than Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plans on the date they become final rather than being delayed to the end of 2015 or the end of the 2015 plan year. As a result, a Non-Hospital/Non-Physician

Services Plan (other than a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan) should not be adopted for the 2015 plan year. (As noted above, it is anticipated that the proposed changes to regulations, when finalized, will not apply to Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plans until after the end of the plan year beginning no later than March 1, 2015. The Departments anticipate that final rulemaking will be completed on or about that date.)

Pending issuance of final regulations, in no event will an employee be required to treat a Non-Hospital/Non-Physician Services Plan as providing MV for purposes of an employee's eligibility for a premium tax credit under Code section 36B, regardless of whether the plan is a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan.

B. Employer Duty to Inform Employees

An employer that offers a Non-Hospital/Non-Physician Services Plan (including a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan) to an employee (1) must not state or imply in any disclosure that the offer of coverage under the Non-Hospital/Non-Physician Services Plan precludes an employee from obtaining a premium tax credit, if otherwise eligible, and (2) must timely correct any prior disclosures that stated or implied that the offer of the Non-Hospital/Non-Physician Services Plan would preclude an otherwise tax-credit-eligible employee from obtaining a premium tax credit. Without such a corrective disclosure, a statement (for example, in a summary of benefits and coverage) that a Non-Hospital/Non-Physician Services Plan provides minimum value will be considered to imply that the offer of such a plan precludes employees from obtaining a premium tax credit. However, an employer that also offers an employee another plan that is not a Non-Hospital/Non/-Physician Services Plan and that is affordable and provides MV is permitted to advise the employee that the offer of this other plan will or may preclude the employee from obtaining a premium tax credit.

FOR FURTHER INFORMATION

The Departments have coordinated on the guidance and other information contained in this notice, and HHS is concurrently issuing parallel guidance. Questions concerning the information contained in this notice may be directed to HHS at 301-492-5153 or the IRS at 202-317-7006. Additional information for employers regarding the Affordable Care Act is available at www.healthcare.gov, www.irs.gov/ACA, and www.business.usa.gov.