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Cc: PA:LPD: PR (Notice 2012-31)

*Submitted via Notice.Comments@IRScounsel.treas.gov*

**RE: Comments on the Minimum Value of an Employer-Sponsored Health Plan Notice, dated May 14 2012.**

To Whom It May Concern:

Consumers Union, the policy and advocacy division of *Consumer Reports*,<sup>1</sup> is pleased to provide the following comments in response to the **Minimum Value of an Employer-Sponsored Health Plan** Notice published May 14, 2012, by the Internal Revenue Service, U.S. Department of Treasury.

The Affordable Care Act is intended to increase access to health coverage that meets minimum standards for affordability and comprehensiveness, and our comments focus on ensuring that families with an offer of coverage from their employer realize these protections.

Under the Act, health insurance plans purchased in the non-group and small-group markets beginning January 1, 2014 are subject to minimum standards for both covered services (the essential health benefits) and limits on cost-sharing charges, resulting in strong coverage floor and a basic level of financial protection for consumers. In the large employer market, plans made available to employees beginning January 1, 2014 are

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<sup>1</sup> *Consumer Reports* is the world's largest independent product-testing organization. Using its more than 50 labs, auto test center, and survey research center, the nonprofit rates thousands of products and services annually. Founded in 1936, *Consumer Reports* has over 8 million subscribers to its magazine, website, and other publications. Its advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and in the marketplace.

subject to fewer requirements.<sup>2</sup> These plans are not required to cover a specific set of services, nor do they have to offer coverage that provides a certain level of financial protection.

However, if an employer fails to offer a plan that meets the affordability or minimum value thresholds that are defined in the statute, employees may be eligible for a federal tax credit to help them purchase Exchange coverage. If an employee obtains a tax credit, employers with at least 50 full-time employees may face a fine. To meet the minimum value threshold, an employer plan's share of the total allowed costs of benefits under the plan must be at least 60 percent. In accordance with the statute and as described in the Notice, the minimum value calculation is essentially a determination of a health plan's actuarial value.

We support many aspects of the approach that Treasury has proposed to calculate an employer plan's minimum value. In particular, we support calculating the minimum value of employer plans in a manner consistent with the actuarial value rules under section 1302(d) of the ACA by being based on a standard population and related to coverage of the essential health benefits. The proposed AV and MV calculators offer a promising method to ease employers' efforts to offer plans that meet the minimum value threshold. To work well, the calculators should be sufficiently robust and capable of capturing the consumer impact of *most* cost-sharing provisions for a *large majority* of plan designs sold in the individual and group markets. In addition to the calculators, Treasury has proposed two additional methods of making the minimum value determination. Each of the alternate methods for calculating MV, if they are adopted, should be implemented so that they produce uniform results. In other words, the choice of method should not disadvantage the consumer.

Our comments include a detailed discussion of what a robust calculator would look like. We also describe the safeguards needed to ensure that the selection of a particular method--particularly the less precise methods--cannot result in an "above 60 percent" finding when a more precise method would have resulted in a finding that the plan was below 60 percent.

The employees most likely to be offered health plans near the 60 percent benchmark will probably be low-wage employees. Lower-wage employees are least able to manage the large out-of-pocket expense associated with a less generous plan and their low incomes mean they will likely benefit from access to tax credits in the exchange. **Therefore, the MV estimates must err on the side of not overstating the value of the employer plan**

The bottom line is that the minimum value test must hold all offers of employer-sponsored coverage to a robust standard for comprehensiveness that, when not met, frees workers and their families to seek more affordable and adequate coverage in an insurance Exchange.

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<sup>2</sup> Some protections that do accrue to enrollees in large employer plans are (1) annual and life-time dollar limits are curtailed, (2) out-of-pocket limits are strengthened and capped, and (3) selected preventive services aren't subject to cost-sharing.

## Ensuring A Robust Calculator

### *Modeling Approach: Continuance Table vs Microsimulation*

The Minimum Value notice anticipates a MV calculator based on continuance tables. While not part of the heavily referenced *Actuarial Value Bulletin*, the notice also implies that continuance tables will be used for the AV calculator for fully-insured individual and small group plans.

We are very concerned about this proposed approach. The continuance table method of estimating actuarial value is much less flexible than the alternative micro-simulation approach. Continuance tables show how population spending is distributed within a population. They are suitable for modeling simple plan designs where the cost-sharing provisions apply to all the costs in the continuance table. For example, the continuance table in Exhibit 1 could be used to estimate the percent of charges a plan would pay if the deductible applied to all charges, there were no exceptions to the out-of-pocket limit and no copay or visit limits.

### **Exhibit 1: Simple Example of a Continuance Table**

Charges per person up to and including	Proportion of total charges below threshold
\$0	.000
\$ 500	.068
\$ 1,000	.122
\$ 10,000	.521
\$ 25,000	.712
\$ 100,000	.896
\$ 500,000	.984
\$ 1,000,000	.996

Source: Adapted from McDevitt and Lore, *Actuarial Value under the Affordable Care Act: Plan Valuation with the Consumer in Mind*, Consumers Union, June 8, 2012

In reality, of course, most plan designs are more complicated. The pharmacy deductible may be “carved out” of the medical deductible, meaning that an overall charge distribution could not be used. Copays are a common cost-sharing provision, as are visit limits, which require numerous, alternate distributions.

For example, a plan featuring a \$500 deductible per hospital admission and \$100 copay per emergency room visit could not be modeled in a continuance table type calculator because these cost-sharing features are not tied to charges. The presence of these provisions lowers the value of the plan for the employee but this loss of value may not be reflected in the calculator's estimate. Further, Treasury proposes to combine inpatient hospital and emergency room into one category. If a continuance table approach were used, Treasury would need to raise the threshold for MV to account for the actuarial value of omissions such as these.

**We highly recommend a micro-simulation approach to the AV and MV calculators.** This modeling approach can easily accommodate copays and visit limits, and has the flexibility to regroup underlying charge categories in any way needed to model the plan.<sup>3</sup>

#### *Scope of Services included in the MV calculator*

To ensure accurate estimates, the calculator (regardless of model approach) should accept a broad array of benefit design elements. For example, tiered cost-sharing for prescription drugs is very common in insurance plans today, and the calculator should be able to accommodate multiple coinsurance percentages and a mix of coinsurance and copayment amounts for this important benefit. The calculator should also be capable of accepting cost-sharing charges that are specific to inpatient, outpatient, and emergency services (including possible deductibles or differing co-insurance or copayments) since these often vary. The model must accept dollar-denominated cost sharing (like deductibles) but also visit limits and other types of inside limits that raise costs for consumers.

Treasury proposes to use a limited set of information to produce estimates through the MV calculator. The notice mentions a limited set of cost-sharing features (deductibles, co-insurance, and maximum out-of-pocket costs) and four core categories of services: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services.

We think this is too limited. **We recommend a broad spectrum of services be included in the calculator.** As noted above, the employees most likely to face health plans near the 60 percent benchmark are low-wage employees. Lower-wage employees are least able to manage the large out-of-pocket expense associated with a less generous plan and they are the most likely to benefit from access to tax credits in the exchange. **Therefore, the MV estimates *must* err on the side of not overstating the value of the employer plan.**

#### *Excluded Services*

As the notice mentions, excluded services (rehabilitative services, durable medical equipment, acupuncture and chiropractic services, and home health services) account for

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<sup>3</sup> For further discussion, please see McDevitt and Lore, *Actuarial Value under the Affordable Care Act: Plan Valuation with the Consumer in Mind*, Consumers Union, June 8, 2012.

about 5 percent of the total of covered services.<sup>4</sup> **In order to not overstate the value of the plan, this five percent “gap” must be accounted for. Our recommendation is to expand the calculator’s ability to account for benefits as described above.**

If the calculator does not take into account additional services, a method should be developed to address cases when a plan excludes such services. For example, after completing the calculator process, plans could be required to certify that they cover a given set of benefits (perhaps those identified in the HHS report) at the same level as other covered services. If the employer does not certify this, then the calculator result would be reduced by an appropriate amount equal to the actuarial value of the missing services. If an employer plan covers some but not all of the specified additional services and wants to get credit in the MV calculation for such coverage, an actuarial determination, consistent with federal standards, could then be used.

In addition, employer plans must cover all the services within a spending category in order to use the calculator for their estimate. For example, if Treasury continues to combine emergency room and inpatient hospital as a single category, and a plan covers emergency room but not inpatient hospital, the employer could not use the calculator to determine minimum value. The employer would have to get an actuarial certification and the final rule must require that the resulting actuarial value estimate is lowered to reflect the absence of inpatient hospital coverage.

#### *Underlying Claims Data Must Be Robust*

Even the more robust micro-simulation modeling approach is only as good as the underlying claims data being used to produce the actuarial estimates. For accuracy, this claims data must include a robust distribution of patients, including high cost patients. The records must have a significant amount of service-level detail so that cost-sharing linked to visits, days, admissions or scripts can be incorporated into the estimate. Service-level detail should include all sub-categories that commonly attract differential cost-sharing provisions such as several tiers of prescription drug charges and scripts; inpatient charges, days and admissions, primary vs. specialty care charges and visits, etc.

The claims data must be representative of the population purchasing in the large group markets in 2014. Treasury proposes to use claims data reflecting typical self-insured employer plans which seems suitable to the task. By using the generous scope of covered services typical to a self-insured employer, employers who cover fewer services would receive a lower actuarial value estimate.

#### *Modeling Transparency*

Assumptions about utilization effects, cost-benchmarking, and other assumptions used to calibrate the model must be public and transparent. The federal government should subject the model to sensitivity testing and make the results of the testing publicly

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<sup>4</sup> <http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf>

available to provide insurers, employers, and consumers with adequate understanding of the strengths and weaknesses of in the model chosen.

## Design-Based Safe Harbor Checklists

Treasury asks for comments on alternatives to the MV and AV calculators, including the use of a safe-harbor checklist.

Since many employer plans will be comfortably above the 60 percent threshold, a design-based safe harbor checklist makes sense, as long as the checklist contains well –defined coverage and cost-sharing minimums that are well above those associated with a 60 percent plan. **For example, the checklist must have a scope of covered services requirement. Any plans that do not cover all the services typically found in self-insured plans (physician and mid-level practitioner care, hospital and emergency room services, generic and brand drugs, laboratory and imaging services, rehabilitative services, durable medical equipment, and home health services) must use a more precise method. These services must be robustly defined.**<sup>5</sup>

**After meeting the initial threshold that all services are covered, the checklist must then require minimum cost-sharing provisions (including consideration of visit limits) that leave the plan comfortably above the 60 percent threshold, for example, targeting a 70 percent threshold to account for the lack of precision that might be present in the checklist.** According to research by ASPE, approximately 96 percent of enrollees in employer-sponsored plans are in plans above a 70 percent actuarial value.<sup>6</sup> Hence, use of a checklist tied to 70 percent standard helps protect consumers while still easing compliance for many employers.

As a rule, any plan designs that are close to the 60 percent threshold should be required to use the most precise method available.

## Actuarial Certification

Treasury asks for comments on actuarial certification as an alternative to the MV and AV calculators. The notice envisions that this method would be used when a plan had “nonstandard” features, such as quantitative limits like a limit on the number of physician visits or covered days in the hospital.

Quantitative limits, such as a limit on the number of physician visits, are common in many plan designs. Hence, they cannot be characterized as non-standard and must be accommodated by the AV and MV calculators. **Given the implications of this rule for low-income workers, it is essential that the MV and AV calculators be able to**

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<sup>5</sup>,CMS checklist for determining whether employer drug coverage is creditable for purposes of Medicare is actually quite extensive, reflecting the need for this type of approach to be highly specific, including by incorporating the scope of covered services. Part D. <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf>

<sup>6</sup> <http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf>

**capture all the types of cost-sharing features (such as visit limits) that are common in the market today.**

Further, even with a robust model, there are likely to be plan designs that don't fit cleanly into the model and require a supplemental analysis to ascertain the plan's actuarial value, for example, multiple in-network tiers. To ensure that accurate and comparable estimates are available for such plans, we recommend:

- Supplementary analysis should be done and certified by an independent actuary, not the insurer's actuary.
- Supplementary analyses should be reviewed by HHS actuaries or state actuaries.
- Supplementary analyses should be public documents.
- HHS should review the approaches used in supplementary analyses every two years to ensure the AV and MV results are accurate and comparable across plans within a state.

Treasury and HHS should anticipate regularly evaluating the calculators to stay up-to-date with new trends in benefit design, using the data from these supplementary analyses to inform the updates.

We provide comments later in this letter on the need for a firm line defining health benefits provided under the plan and specific types of benefits that should not be including the minimum value calculation. These comments also apply in the case of a plan receiving an actuarial certification.

## **Treatment of HSAs and HRAs in Calculating Minimum Value**

We support Treasury's intention to ensure that individual contributions to an HSA would not be included in the calculation of minimum value. We also agree that an employer-sponsored plan combined with an HRA would be included in the minimum value calculation but a "standalone" HRA not associated with health coverage would not count toward minimum value. This is important to ensure the minimum value standard is based on whether someone has an adequate offer of health insurance from an employer and not just an account that could be used for health-related expenses.

These comments offer several recommendations for improving the intended treatment of HSAs and HRAs in calculating minimum value. Our primary concern is ensuring consumers with an account-linked offer of employer-sponsored insurance have access to coverage that on the whole meets the minimum value standard or are able to obtain more comprehensive and affordable coverage through an insurance exchange.

### Assumption that Funds Would Be Used for Cost-Sharing Charges

We support the proposal to count an employer's contribution to an HSA or the amount first made available under an HRA used by the employee to pay for cost-sharing charges

under the associated health plan in that year toward the minimum value calculation. This would result in a portion of the employer contribution, and not the entire dollar amount, being included in the minimum value calculation, in recognition that not all of the employer's contribution will be used for health expenses in a given year. We agree that current-year HSA contributions and amounts first made available under an HRA by an employer, but not prior year contributions or investment gains, would be included in the calculation.

Employers have a significant amount of discretion over the details and restrictions of an HRA. They can specify that the amounts in the account only be used for health insurance premiums or for vision and dental benefits, for example. Therefore, **we recommend that an HRA account be included in the minimum value calculation of an employer offer of coverage only to the extent the funds in the HRA actually could be used by the account holder to pay for the cost-sharing charges under the plan.** An HRA that is restricted to other uses should not be included in the calculation because a consumer could not utilize it in the manner assumed.

#### Health Plans, Not HRAs or HSAs, Should Provide the Large Majority of MV

**For both HSAs and HRAs, we recommend that Treasury consider the employer contribution to such accounts as part of the MV only when the associated, employer-sponsored health plan provides the large majority of the value in the AV calculation.** This is particularly important in the case of employer plans that are not subject to the ACA's Essential Health Benefits (EHB) requirements, including large-group and self-insured plans.<sup>7</sup>

But it may be possible for employers not subject to the EHB requirements to cover a limited set of benefits or provide benefits with significant limitations under a health plan and still meet the minimum value standard by depositing funds in an HSA or HRA.<sup>8</sup> For example, an employer-sponsored health plan could fail to cover prescription drugs or could provide coverage of hospital care and physician visits but with limitations on visits and hospital days. While the MV calculation proposed by Treasury would capture such gaps and limitations, it may be possible for the employer to make up significant shortfalls in the minimum value by placing funds in an HSA or HRA. For workers with significant health needs, and healthy workers who suddenly experience an accident or unexpected illness, having cash in an account would not be sufficient to make up for severe limitations on or gaps in the benefits employer-sponsored health plan. The minimum value calculation should take this into account. While it would be reasonable for an

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<sup>7</sup> It appears difficult for a small employer plan (subject to the essential health benefits requirements) to have an AV of much less than 60 percent (because the plan must cover the essential health benefits, include a limited annual deductible, and cap annual enrollee out-of-pocket spending).

<sup>8</sup> We note that under section 2707(b) of the ACA, all group health plans would be required beginning in 2014 to have a cap on out-of-pocket spending under the plan consistent with those established under section 1302(c) of the ACA. This would prevent a health plan, including one associated with an HRA, from having extremely high out-of-pocket charges. The problem of missing or very limited benefits still could arise.

employer plan to have an MV of 55 percent and to reach the 60 percent threshold by providing a contribution to an HSA or HRA, we would be concerned about health insurance coverage that is worth 30 percent or 40 percent in minimum value and the impact that such limited coverage would have on enrollees.

## **Treatment of Benefits Not In the AV or MV Calculator**

Treasury invites comment on whether and how the actuarial value initially generated by the AV calculator or the MV calculator could be adjusted through actuarial certification to take into consideration other benefits provided under the plan.

As noted above, the calculator should have a broad array of benefit design elements including a broad spectrum of services covered by employer sponsored self-insured plans and large group plans. For reasons of simplicity and consistency, the checklist should also be based on the same robust set of services as included in the calculators. Under this approach, there would rarely be a need to use actuarial certification to take into consideration other benefits provided by the plan.

If the final calculator includes few services and/or less service detail, then the recommendations below are vital. The use of a certified actuary is the only way to ensure the value of additional benefits are accounted for correctly but there must be very clear guidelines as to how to accomplish this.

### *Clearly Define What Count as Health Benefits Provided Under the Plan*

Employers offer many benefits that may be of value to employees, but there needs to be a firm line defining when a provision is a health benefit and is provided under the plan and when these conditions have not been met. This is important not only for purposes of whether a benefit outside the AV or MV calculator should be taken into consideration; it is also relevant to cases when a plan receives an MV certification from a certified actuary. Consistency in the definition of services that can count towards minimum value will ensure that employees can trust the minimum value calculation.

For purposes of the MV, **we urge the Department to rigorously define “a health benefit offered under a plan” based on the types of services offered by the typical employer plans.**

In determining the definition, the Department should consider existing laws defining health benefits, the intent of the Affordable Care Act, and whether the services are primarily a benefit to the employee or the employer. Below, we describe four types of services that are clearly not health benefits offered under the plan and that should explicitly be prevented from increasing the MV under any definition chosen by the Department. These services are (1) medical services required for a job, (2) excepted benefits, (3) wellness programs and (4) disease management or other utilization management.

### *Medical Services Required for a Job*

Medical services required by the employer for performance of the job or benefit of the employer should not be included in the calculation. These are employer requirements, not employee benefits. The types of medical services could include, but are not limited to: drug testing, a mandatory physical exam, a test of physical capabilities such as an eye exam or endurance test; or services related to workers compensation. These services may be provided onsite by the employer, at a clinic operated by the employer, by a provider contracting with the employer, or at a specified provider's office. The services may be paid directly by the employer or reimbursed by the employer.

### *Excepted Benefits*

Excepted benefits should not be included in the calculation. Excepted benefits are benefits that are not health benefits or are, in one of the ways detailed in IRC 9832(c), offered separately or not in coordination with the health plan. Examples of benefits that may be excepted benefits and are health related are long-term care benefits, coverage only for a specific disease, limited vision or dental benefits, disability insurance, and some hospital indemnity or fixed indemnity insurance plans. While many excepted benefit plans provide important benefits to employees, they are by definition under IRC 9832(c) not a part of the health plan.

In addition, these benefits are excepted from many employee protections, including regulation by the Affordable Care Act, and are specifically excluded from being minimum essential benefits. (ACA 1502(f)(3)) The specific exclusion from the Affordable Care Act shows clear Congressional intent that excepted benefits are not part of the employer's coverage to be calculated as minimum value. If these benefits were allowed to be calculated as part of MV, it could result in situations in which employees are denied access to affordable coverage in the Exchange with all the protections of the Affordable Care Act because of an offer of coverage with minimal protections. It should be noted that some insurers are marketing fixed indemnity insurance plans as ways to offer benefits that are not impacted by the ACA requirements on group medical coverage.

### *Wellness Programs*

Wellness programs should not be used to increase the MV of a plan. While we support efforts to promote wellness and prevention, we believe there are many types of wellness programs that should not be included in the MV calculation.

Some wellness programs offer additional benefits, such as discounted or free gym memberships, weight loss program memberships, healthy food offered in the work place, entrance fees to races, health fairs, or incentives such as gift cards or raffles to employees that participate in programs health risk assessments or meet certain goals such as

exercise, weight loss or smoking cessation. These benefits are not health coverage and should not be allowed to be added to the minimum value calculation.

Other wellness programs offer incentives or penalties based on activities or health status that impact the premium or cost-sharing design of a plan. For example, a plan may have a \$1,000 deductible, but provide incentives that can reduce the deductible to \$500. Alternatively, a plan may have a \$500 deductible, but provide penalties that can raise the deductible to \$1,000.

Penalties tied to health outcomes may also place certain individuals and populations at a disadvantage, especially those that face environmental or socioeconomic barriers to changing their lifestyle or health status. These challenges include child or elder care obligations, unsafe walking/biking trails or limited access to recreational facilities, the need to hold a second or third job, and limited access to healthy, affordable foods. Unfortunately, it is often the low-income or least educated employees who face these obstacles and disproportionately suffer health disparities.<sup>9</sup> As a result, the highest wage employees may be able to benefit from a wellness program while the lowest wage employees are unable to participate in the offered benefits or take actions necessarily to have the lowest cost-sharing.

For these reasons, wellness programs should not be used to increase the MV of a plan. This is the only way to maintain equity and ensure that employees are not being prevented from accessing affordable coverage while only being able to access a plan that has an MV lower than 60%.

Wellness programs may be added by employers in order to reduce overall compensation costs rather than as a benefit to employees. Wellness programs are often advertised to employers by benefit companies or benefit consultants as a way to save money, not only by reducing health benefit costs but also by decreasing absenteeism and improving productivity.<sup>10</sup> The use of these benefits to reduce costs adds to the financial betterment of the employer rather than functioning primarily as a benefit to *all* employees. In fact, if the wellness program increases costs for an employee – either by using penalties or by increasing cost-sharing or premiums and then providing incentives – the program will reduce access to health care for some employees.

**We recommend that (1) wellness programs that have no impact on cost-sharing, such as gym memberships or health fairs, have no impact on the MV calculation and that (2) the highest possible cost-sharing that an employee could pay under a wellness program that uses incentives or penalties in the plan design be used when calculating MV.**

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<sup>9</sup> Lewis, R. J., W. W. Huebner, et al. (1996). "Characteristics of participants and nonparticipants in worksite health promotion." *Am J Health Promotion* 11(2): 99-106.

<sup>10</sup> For examples, see: <http://www.infinetwellnesssolutions.com/>, <http://www.sbnonline.com/2012/05/your-health-insurer-wants-to-save-you-money/>, <http://www.jwterrell.com/bewell/wellnessresources.html>

## *Disease Management or Other Utilization Management*

In addition to wellness programs, employers may also add disease management programs or other programs designed to reduce health costs. Some of these programs, such as disease management, may provide some services to employees, such as a nurse calling to talk to an employee about a treatment plan. However, the main goal of these programs is to reduce benefit costs. Similar to wellness programs, these are not actually offered to solely benefit employees. **Disease management programs and other utilization management should not be included in the MV calculation.**

## **De Minimis Variation is Not Needed**

The HHS bulletin on actuarial value proposes allowing “*de minimis*” variation of +/- 2 percentage points around the actuarial benchmarks of 60, 70, 80, and 90 percent. **In the case of minimum value, we do not believe this latitude is needed or warranted.** The *de minimis* variation was provided in the AV context because plans must achieve specific, narrower AV targets and because allowing some variation from the targets would permit greater consistency in enrollee cost-sharing charges from year to year. The MV threshold does not raise the same issues because it functions as a threshold, not a means of navigating health plan choices. As noted above, the MV calculation should err on the side of the employee and ensure that the measurement method does not deprive them of a tax credit that they would be entitled to had a more precise measurement method been used.

## **Conclusion**

The clear intent of the law is to ensure that employer coverage provides at least minimum value and that, if it does not, employees may be able to access better and more affordable coverage in the Exchange.

To work well, the calculators used to make the minimum value determination should be robust and capable of capturing the consumer impact of *most* cost-sharing provisions for a *large majority* of plan designs sold in the group market. The insurer or employers choice of estimation method should not disadvantage the consumer. Therefore, each MV estimation method *must* err on the side of not overstating the value of the employer plan.

Sincerely,

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