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Determining Minimum Value of Health Plan Coverage

Beginning in 2014, the Affordable Care Act (ACA) provides premium tax credits and cost-sharing reductions to eligible individuals who purchase qualified health plan coverage through a health insurance Exchange (Exchange). To qualify for these subsidies, an individual cannot be eligible for other minimum essential health coverage, including coverage under an employer-sponsored plan that is affordable and provides minimum value.

An applicable large employer (ALE) may be liable for a penalty under the ACA's "pay or play" rules if any of its full-time employees receives a premium tax credit or cost-sharing reduction through an Exchange. This may happen if an ALE's plan does not provide minimum value. An employer is an "applicable large employer" for a calendar year if it employed an average of at least 50 full-time employees, including full-time equivalents, on business days during the preceding calendar year.

EMPLOYER PAY OR PLAY RULES—EFFECTIVE DATE

The employer mandate provisions were set to take effect on Jan. 1, 2014. However, on July 2, 2013, the Treasury delayed the employer mandate penalties and related reporting requirements for one year, until 2015. On Feb. 12, 2014, the IRS published final regulations on the ACA's pay or play rules. Under the final regulations:

- ALEs that have **fewer than 100 full-time employees** generally will have an additional year, **until 2016**, to comply with the pay or play rules.
- ALEs with **100 or more full-time employees** must comply with the pay or play rules starting in **2015**.

MINIMUM VALUE REQUIREMENTS

Under the ACA, a plan fails to provide minimum value (MV) if the plan's share of total allowed costs of benefits provided under the plan is less than **60 percent** of those costs. MV is calculated by:

- Dividing the cost of essential health benefits (EHBs) the plan would pay for a standard population by the total cost of EHBs for the standard population (including amounts the plan pays and amounts the employee pays through cost-sharing); and
- Converting the result to a percentage.

On Feb. 25, 2013, HHS issued a final rule on EHBs, which finalizes four approaches for determining MV. On May 3, 2013, the IRS released a proposed rule to provide additional guidance on the ACA's MV requirements.

In addition, on Nov. 4, 2014, the IRS issued Notice 2014-69 to clarify that plans that do not provide in-patient hospitalization or physician services (referred to as Non-Hospital/Non-Physician Services Plans) do not provide the minimum value intended by the ACA. Likewise, HHS' final Notice of Benefit and Payment Parameters for 2016 clarifies that, in order to provide MV, a plan must not only cover a predicted 60 percent of the allowed costs under the plan, but it must also provide a benefit package that reflects benefits historically provided under "major medical" employer coverage. Specifically, to satisfy the minimum value requirement, coverage must include substantial coverage of both inpatient hospital services and physician services.

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FOUR APPROACHES

An employer may use one of the following methods to determine if its health plan provides MV:

MV Calculator

The MV Calculator allows an employer to enter information about its health plan's benefits, coverage of services and cost-sharing terms to determine whether the plan provides MV. MV Calculator Methodology is also available, which provides a detailed description of the data underlying the MV Calculator and its methodology.

If a plan uses the MV Calculator and offers an EHB outside of the parameters of the MV Calculator, the plan may ask an actuary to determine the value of the benefit and add it to the result derived from the MV Calculator to reflect that value.

Safe Harbor Checklists

Design-based safe harbors in the form of checklists allow employers to compare their plans' coverage to the checklists. If the employer-sponsored plan's terms are consistent with or more generous than any one of the safe harbor checklists, the plan will be treated as providing MV. This method will not involve calculations and can be completed without an actuary.

The IRS proposed the following plan designs as safe harbors for determining MV, if the plan covers all of the benefits included in the MV Calculator:

- ✓ ***Option One:*** A plan with a $3,500 integrated medical and drug deductible, 80 percent plan cost sharing and a $6,000 maximum out-of-pocket limit for employee cost-sharing;
- ✓ ***Option Two:*** A plan with a $4,500 integrated medical and drug deductible, 70 percent plan cost sharing, a $6,400 maximum out-of-pocket limit and a $500 employer contribution to a health savings account (HSA); and
- ✓ ***Option Three:*** A plan with a $3,500 medical deductible, $0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a $6,400 maximum out-of-pocket limit and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75 percent coinsurance for specialty drugs.

The IRS indicated that additional safe harbor plan designs will be described in future guidance.

Actuarial Certification

An employer-sponsored plan may seek certification by an actuary to determine the plan's MV if the plan contains nonstandard features that preclude the use of the MV Calculator and safe harbor checklists. Nonstandard features would include quantitative limits (for example, limits on covered hospital days or physician visits) on certain core categories of benefits and services.

Under this approach, plans will be able to generate an initial value using a calculator and then engage a certified actuary to make appropriate adjustments to take into consideration the nonstandard features.

Metal Level

Any plan in the small group market that meets any of the "metal levels" of coverage (that is, bronze, silver, gold or platinum) provides MV.

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HEALTH BENEFITS MEASURED

In determining the share of benefit costs paid by a plan, the proposed rule does not require employer-sponsored large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to qualified health plans (QHPs). Employer-sponsored group health plans are not required to offer EHBs unless they are health plans offered in the small group market. MV is measured based on the provision of EHBs to a standard population and plans may account for any benefits covered by the employer that also are covered in any one of the EHB benchmark plans.

The proposed rule provides that MV is based on the anticipated spending for a standard population. The plan's anticipated spending for benefits provided under any particular EHB-benchmark plan for any state counts towards MV. The proposed rule provides that the standard population used to determine MV reflects the population covered by self-insured group health plans.

HSA AND HRA CONTRIBUTIONS

The proposed rule provides that all amounts contributed by an employer for the current plan year to a health savings account (HSA) are taken into account in determining the plan's share of costs for purposes of MV, and are treated as amounts available for first dollar coverage.

Amounts newly made available for the current plan year under a health reimbursement arrangement (HRA) that is integrated with an eligible employer-sponsored plan count for purposes of MV, as long as the amounts may be used only for cost-sharing and may not be used to pay insurance premiums.

On Sept. 13, 2013, the DOL issued Technical Release 2013-03, which provides detailed guidance on when an HRA will be considered integrated with other group health coverage. This guidance is generally effective for plan years beginning on or after Jan. 1, 2014, although it may be applied for all prior periods. The Technical Release contains the following guidance on including HRA contributions in the MV calculation:

- Even if an HRA is integrated with a plan offered by another employer for purposes of the ACA's annual dollar limit prohibition and the preventive services requirements, the HRA does not count toward the affordability or MV requirement of the plan offered by the other employer.
- Additionally, if an employer offers an HRA on the condition that the employee does not enroll in non-HRA coverage offered by the employer and instead enrolls in non-HRA coverage from a different source, the HRA does not count in determining whether the employer's non-HRA coverage satisfies either the affordability or MV requirement.

WELLNESS PROGRAM COST-SHARING REDUCTIONS

In addition, the proposed rule addresses how nondiscriminatory wellness program incentives that may affect an employee's cost sharing should be taken into account for purposes of the MV calculation. The proposed rule provides that a plan's share of costs for MV purposes is determined **without regard to reduced cost-sharing available under a nondiscriminatory wellness program**.

However, for nondiscriminatory wellness programs designed to prevent or reduce tobacco use, MV may be calculated assuming that every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use. This exception is consistent with other ACA provisions (such as the ability to charge higher premiums based on tobacco use) reflecting a policy about individual responsibility regarding tobacco use.

Transition relief is provided in the proposed rule for plan years beginning before Jan. 1, 2015. Under this relief, if an employee receives a premium tax credit because an employer-sponsored health plan is unaffordable or does not provide MV, but the employer coverage would have been affordable or provided MV had the employee satisfied the requirements of a nondiscriminatory wellness program (as in effect on May 3, 2013), the employer will not be subject to the employer penalty. It is unclear how the delay of the employer mandate penalties impacts this transition relief.

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LOW-COST EMPLOYER PLANS

In Notice 2014-69, the IRS clarifies that Non-Hospital/Non-Physician Services Plans do not provide the MV intended under the ACA. In addition, the final Notice of Benefit and Payment Parameters for 2016 states that an employer-sponsored plan provides MV only if:

- The percentage of the total allowed cost 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.

Accordingly, an employer will not be permitted to rely on the MV Calculator (or any actuarial certification or valuation) to demonstrate that a Non-Hospital/Non-Physician Services Plan provides MV.

The final rule applies to employer-sponsored plans, including plans that are in the middle of a plan year, beginning on **April 28, 2015** (the effective date of the final rule). As a result, a Non-Hospital/Non-Physician Services Plan (other than a Pre-Nov. 4, 2014, Non-Hospital/Non-Physician Services Plan) should not be adopted for the 2015 plan year.

Transition Relief

Notice 2014-69 and the final rule provide transition relief for employers that have entered into a binding written commitment to adopt, or have begun enrolling employees in, a Non-Hospital/Non-Physician Services Plan prior to Nov. 4, 2014, based on the employer's reliance on the results of use of the MV Calculator (referred to as a Pre-Nov. 4, 2014, Non-Hospital/Non-Physician Services Plan). For these purposes, a binding written commitment exists when:

- An employer is contractually required to pay for an arrangement; and
- A plan begins enrolling employees when it begins accepting employee elections to participate in the plan.

Solely in these situations, the final rules will not apply to the plan before the end of the plan year (as in effect under the terms of the plan on Nov. 3, 2014), as long as that plan year begins no later than March 1, 2015.

Exchange Subsidy Eligibility

The IRS is expected to publish proposed regulations making clear that this delayed applicability date applies solely for purposes of the employer shared responsibility rules. An employee who is covered under a Non-Hospital/Non-Physician Services Plan will not be treated as having been offered MV coverage for purposes of eligibility for an Exchange subsidy. This is the case regardless of whether the plan is a Pre-Nov. 4, 2014, Non-Hospital/Non-Physician Services Plan.

Employer Disclosure Requirements

An employer that offers a Non-Hospital/Non-Physician Services Plan (including a Pre-Nov. 4, 2014, Non-Hospital/Non-Physician Services Plan) to an employee 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.

In addition, the employer must, in a timely manner, 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 this corrective disclosure, a statement (for example, in a summary of benefits and coverage) that a Non-Hospital/Non-Physician Services Plan provides MV 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 to an employee another plan that is not a Non-Hospital/Non-Physician Services Plan and that is affordable and provides MV may advise the employee that the offer of this other plan will (or may) preclude the employee from obtaining a premium tax credit.