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Proposed Rule Released on Minimum Value and Affordability

On May 3, 2013, the Internal Revenue Service (IRS) released a **proposed rule** on the minimum value and affordability rules under the Affordable Care Act (ACA). In this proposed rule, the IRS provides guidance on determining whether health coverage under an employer-sponsored plan is affordable and provides minimum value for purposes of determining the employer "pay or play" penalties. In particular, the proposed regulation:

- Explains how to calculate minimum value (MV);
- Outlines special rules for determining how health reimbursement arrangements (HRAs), health savings accounts (HSAs) and wellness program incentives are counted in determining MV and affordability; and
- Provides new safe harbors for determining MV.

This proposed rule would apply for tax years ending after Dec. 31, 2013.

BACKGROUND

Effective for 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 the premium tax credit and cost-sharing reductions, an individual cannot be eligible for other minimum essential health coverage, including coverage under an employer-sponsored plan that is affordable to the individual and provides minimum value.

A large employer may be liable for a penalty under 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 a large employer's plan does not provide minimum value. An employer is a "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.

In addition, under ACA's individual mandate, individuals are generally required to pay a penalty if they do not have minimum essential coverage. ACA also contains reporting requirements to implement the law's penalty provisions for large employers and individuals.

MINIMUM VALUE REQUIREMENTS

ACA provides that a plan does not provide minimum value (MV) if the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent. 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 then converting the result to a percentage.

Health Benefits Measured in Determining Minimum Value

In determining the share of benefit costs paid by a plan, the proposed regulations do not require employer-sponsored large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to 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 regulations provide 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.

Rules for HRA and HSA Contributions

The proposed regulations also address how employer contributions toward HSAs or HRAs should count toward the plan's share of costs in determining MV. The proposed rule provides that all amounts contributed by an employer for the current plan year to an 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 under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year count for purposes of MV in the same manner, as long as the amounts may be used only for cost-sharing and may not be used to pay insurance premiums.

Rules for 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 regulations provide 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.

Standard Population

The proposed regulations provide that the standard population used to determine MV reflects the population covered by self-insured group health plans. HHS has developed the MV standard population and described it through summary statistics (for example, continuance tables). MV continuance tables and an explanation of the MV Calculator methodology and the health claims data HHS has used to develop the continuance tables are available on the Center for Consumer Information & Insurance Oversight website.

AFFORDABILITY REQUIREMENTS

Under the ACA, eligible employer-sponsored coverage is affordable only if an employee's required contribution for self-only coverage does not exceed 9.5 percent of household income. Although the rule measures affordability based on household income, employers may find it difficult to determine an employee's household income because they generally will not know the income levels of their employees' family members. As a result, the IRS established three safe harbors for employers to use, which measure affordability based on the employee's **W-2 wages**, the employee's **rate of pay** or the **federal poverty level for a single individual**.

The proposed regulation includes special rules for determining how HRAs and wellness program incentives are counted in determining the affordability of eligible employer-sponsored coverage. The proposed rule provides that amounts made newly available under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year are taken into account only in determining affordability if the employee may either:

- Use the amounts only for premiums; or
- Choose to use the amounts for either premiums or cost-sharing.

Treating amounts that may be used either for premiums or cost-sharing only toward affordability prevents double counting the HRA amounts when assessing MV and affordability of eligible employer-sponsored coverage.

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The proposed rules also contain clarification on affordability when premiums may be affected by **wellness programs**. Under the proposal, the affordability of an employer-sponsored plan is determined by assuming that each employee fails to satisfy the wellness program's requirements, unless the wellness program is related to tobacco use. This means the affordability of a plan that charges a higher initial premium for tobacco users will be determined based on the premium charged to non-tobacco users, or tobacco users who complete the related wellness program, such as attending smoking cessation classes.

Transition relief is provided in the proposed rules 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 minimum value, but the employer coverage would have been affordable or provided minimum value had the employee satisfied the requirements of a nondiscriminatory wellness program that was in effect on May 3, 2013, the employer will *not* be subject to the employer mandate penalty. The transition relief applies for rewards expressed as either a dollar amount or a fraction of the total required employee premium contribution.

NEW SAFE HARBORS FOR DETERMINING MINIMUM VALUE

In May 2012, the IRS issued Notice 2012-31 to propose several methods for determining MV: the MV Calculator, a safe harbor, actuarial certification and, for small group market plans, a metal level. The proposed regulations provide that taxpayers may determine whether a plan provides MV by using the MV Calculator. Taxpayers must use the MV Calculator to measure standard plan features (unless a safe harbor applies), but the percentage may be adjusted based on an actuarial analysis of plan features that are outside the parameters of the calculator.

Certain safe harbor plan designs that satisfy MV will be specified in additional guidance. It is anticipated that the guidance will provide that the safe harbors are examples of plan designs that clearly would satisfy the 60 percent threshold if measured using the MV Calculator. The safe harbors are intended to provide an easy way for sponsors of typical employer sponsored group health plans to determine whether a plan meets the MV threshold without having to use the MV Calculator. Plan designs meeting the following specifications are proposed as safe harbors for determining MV if the plans cover all of the benefits included in the MV Calculator:

- 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;
- 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 an HSA; and
- 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.

Comments are requested on these and other common plan designs that would satisfy MV and should be designated as safe harbors. The proposed regulations require plans with nonstandard features that cannot determine MV using the MV Calculator or a safe harbor to use the actuarial certification method. The actuary must be a member of the American Academy of Actuaries and must perform the analysis in accordance with generally accepted actuarial principles and methodologies and any additional standards that subsequent guidance requires.

OTHER ISSUES IN THE PROPOSED REGULATIONS

Definition of Modified Adjusted Gross Income

The term "household income" means the modified adjusted gross income of the taxpayer plus the modified adjusted gross income of all members of the taxpayer's family required to file a tax return for the taxable year. The final regulations provide that the determination of whether a family member is required to file a return is made without regard to Code section 1(g)(7), which allows a parent to elect to include in the parent's gross income the gross

income of his or her child, if certain requirements are met. If the parent makes the selection, the child is treated as having no gross income for the taxable year.

The proposed regulations remove "without regard to section 1(g)(7)" from the final regulations because that language implies that the child's gross income is included in both the parent's adjusted gross income and the child's adjusted gross income in determining household income. Thus, the proposed regulations clarify that if a parent makes an election under section 1(g)(7), household income includes the child's gross income included on the parent's return and the child is treated as having no gross income.

Retiree Coverage

An individual who may enroll in continuation coverage required under federal or state law that provides comparable continuation coverage is eligible for minimum essential coverage only for months that the individual is enrolled in the coverage. The proposed regulations apply this rule to **former employees only**. Active employees eligible for continuation coverage as a result of reduced hours should be subject to the same rules for eligibility of affordable employer-sponsored coverage offering MV as other active employees.

The proposed regulations add a comparable rule for health coverage offered to retired employees (retiree coverage). Accordingly, an individual who may enroll in retiree coverage is eligible for minimum essential coverage under the coverage only for the months the individual is enrolled in the coverage.

Coverage Month for Newborns and New Adoptees

A month is a coverage month for an individual only if, as of the first day of the month, the individual is enrolled in a QHP through an Exchange. A child born or adopted during the month is not enrolled in coverage on the first day and therefore would not be eligible for the premium tax credit or cost-sharing reductions for that month. Accordingly, the proposed regulations provide that a child enrolled in a QHP in the month of the child's birth, adoption or placement with the taxpayer for adoption or in foster care, is **treated as enrolled as of the first day of the month**.

Adjusted Monthly Premium for Family Members Enrolled for Less Than a Full Month

The premium assistance amount for a coverage month is computed by reference to the adjusted monthly premium for an applicable benchmark plan. The final regulations provide that the applicable benchmark plan is the plan that applies to a taxpayer's coverage family. The final regulations do not address whether changes to a coverage family (for example, as the result of the birth and enrollment of a child or the disenrollment of another family member) that occur during the month affect the premium assistance amount. The proposed regulations provide that the adjusted monthly premium is determined as if all members of the coverage family for that month were enrolled in a QHP for the entire month.

Premium Assistance Amount for Partial Months of Coverage

The final regulations do not address the computation of the premium assistance amount if coverage under a QHP is terminated during the month. The proposed regulations provide that when coverage under a QHP is terminated before the last day of a month and, as a result, the issuer reduces or refunds a portion of the monthly premium, the premium assistance amount for the month is prorated based on the number of days of coverage in the month.

Family Members Residing at Different Locations

The final regulations reserved rules on determining the premium for the applicable benchmark plan if family members are geographically separated and enroll in separate QHPs. The proposed regulations provide that the premium for the applicable benchmark plan in this situation is the sum of the premiums for the applicable benchmark plans for each group of family members residing in a different state.

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Correction to Applicable Percentage Table

The applicable percentage table in the final regulations incorrectly states that the 9.5 percentage applies only to taxpayers whose household income is **less than** 400 percent of the FPL. The proposed regulations clarify that the 9.5 percentage applies to taxpayers whose household income is **not more than** 400 percent of the FPL.

Additional Benefits and Applicable Benchmark Plan

Under section 36B(b)(3)(D) and the final regulations, only the portion of the premium for a QHP properly allocable to EHBs determines a taxpayer's premium assistance amount. Premiums allocable to benefits other than EHBs (additional benefits) are disregarded. The final regulations do not address, however, whether a taxpayer's benchmark plan is determined before or after premiums have been allocated to additional benefits.

The proposed regulations provide that premiums are allocated to additional benefits before determining the applicable benchmark plan. Thus, **only EHBs are considered** in determining the applicable benchmark plan, consistent with the requirement in section 36B(b)(3)(D) that only EHBs are considered in determining the premium assistance amount. In addition, allocating premium to benefits that exceed EHBs before determining the applicable benchmark plan results in a more accurate determination of the premium assistance amount.

Source: Internal Revenue Service