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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 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 applicable large employer's plan does not provide minimum value. An employer is a "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 announced **the delay of the employer mandate penalties and related reporting requirements for one year, until 2015**. Therefore, these payments will not apply for 2014. On July 9, 2013, the IRS issued [Notice 2013-45](#) to provide more formal guidance on the delay. No other provisions of the ACA are affected by the delay.

On Feb. 12, 2014, the IRS published [final regulations](#) on the ACA's pay or play rules. These regulations finalize provisions in [proposed regulations](#) released by the IRS on Jan. 2, 2013. Under the final regulations:

- Applicable large employers that have **fewer than 100 full-time employees** generally will have an additional year, **until 2016**, to comply with the pay or play rules.
- Applicable large employers 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 if the plan's share of total allowed costs of benefits provided under the plan is less than **60 percent** of those costs.

Minimum value 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.

The IRS and Department of Health and Human Services (HHS) have released guidance on methods for determining minimum value under the ACA. On Feb. 25, 2013, HHS issued a [final rule](#) on EHBs, which finalizes four approaches for determining minimum value. On May 3, 2013, the IRS released a [proposed rule](#) to provide additional guidance on the ACA's minimum value requirements.

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FOUR APPROACHES

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

MV Calculator

HHS released an [MV Calculator](#) that permits an employer to enter information about its health plan's benefits, coverage of services and cost-sharing terms to determine whether the plan provides minimum value. HHS also released an [MV Calculator Methodology](#), 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

HHS and the IRS will provide design-based safe harbors in the form of checklists that employers can use to compare to their plans' coverage. 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 minimum value. 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 minimum value 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.

Actuarial Certification

An employer-sponsored plan may seek certification by an actuary to determine the plan's minimum value 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 minimum value.

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

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plans (QHPs). Employer-sponsored group health plans are not required to offer EHBs unless they are health plans offered in the small group market. Minimum value 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 minimum value 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 minimum value. The proposed rule provides that the standard population used to determine minimum value 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 minimum value 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 minimum value, 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 minimum value 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 minimum value 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 minimum value 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 minimum value calculation. The proposed rule provides that a plan's share of costs for minimum value 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, minimum value 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 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 (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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