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REFORM Update

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The Internal Revenue Service recently released proposed guidance on a number of issues, including:

- Minimum value calculation
- Affordability test
- Individual premium tax credit

This latest proposed guidance clarifies several health care reform requirements.

Minimum Value Calculation

To avoid an annual $2,000 penalty, employers subject to the "play or pay" rules must offer minimum essential coverage to 95 percent of full-time employees (and dependent children). Employees working 30 or more hours a week are considered full-time. An employer-sponsored health plan that is not a HIPAA-excepted benefit is considered minimum essential coverage.

To avoid an annual $3,000 penalty, employers must offer full-time employees a group health plan that meets two specific requirements. First, the health plan must satisfy the minimum value standard. A minimum value plan must offer at least a 60 percent benefit. Second, the group health plan must be affordable. An affordable plan is one that does not cost more than 9.5% of the employee's household income for single coverage. Employers may have to pay the $3,000 penalty if they do not offer an affordable minimum value plan. They must pay a penalty if a full-time employee, not eligible for affordable, minimum value coverage, obtains subsidized coverage in the Health Insurance Marketplace.

Employers may use several methods to measure minimum value:

1. **Minimum value calculator.** This government-developed calculator allows employers to enter various cost-sharing elements. The calculator then determines the plan's minimum value. The minimum value calculator can be found at **http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html**. It is under the "Plan Management" section.
2. **Safe harbor checklist.** The government will create a number of safe harbor checklists so that an employer can determine whether a plan is of minimum value.
3. **Actuarial determination.** An actuary must determine the minimum value if the employer cannot measure the plan design using either of these methods.

The proposed guidance provides more details on measuring minimum value:

- Small group health plans purchased through the Marketplace can rely on the metal tier determination. If the plan meets a platinum, gold, silver or bronze tier, the plan does provide minimum value.
- There is no de minimis variation allowed for measuring minimum value. The plan must have at least a 60 percent value.
- Some employers have fully insured high deductible health plans. They may self-fund a health reimbursement arrangement (HRA) to help offset the high deductible for their employees. They **can** use current-year HRA funds to determine minimum value as long as the HRA funds can **only** be used to offset cost-sharing. If HRA funds are used for both cost-sharing and reimbursing health insurance premiums, then the funds should not be used to determine the minimum value.
- Some employers offer a high deductible health plan paired with a health savings account (HSA). Any current-year employer funding of the HSA should be used in determining minimum value. The current-year employer funding is treated as amounts available for first-dollar coverage.
- Some plans may have cost-sharing elements that vary based on whether participants meet wellness plan requirements. In these situations, the employer must measure the minimum value without regard to the cost-sharing improvements available to participants that meet the wellness program requirements. The regulations make an exception for nondiscriminatory wellness programs designed to **prevent or reduce tobacco use**. Employers may calculate the minimum value by assuming that every participant satisfies the wellness program's requirement to curb tobacco use.

The proposed rules also ask for specific comments on safe harbor plan designs. The following plan designs are proposed as safe harbors for 60 percent minimum value, so long as the plan covers all benefits included in the minimum value calculation:

1. Plan 1:
    a. Integrated $3,500 medical and drug deductible
    b. 80 percent plan cost-sharing
    c. $6,000 maximum out-of-pocket limit
2. Plan 2:
    a. Integrated $4,500 medical and drug deductible
    b. 70 percent plan cost-sharing
    c. $6,400 maximum out-of-pocket limit
    d. $500 employer contribution to an employee's HSA
3. Plan 3:
    a. $3,500 medical deductible
    b. No drug deductible
    c. 60 percent medical plan cost-sharing

d. Prescription drug copays of $10 for first tier, $20 for second tier, $50 for third tier, and 75 percent cost-sharing for specialty medications
e. $6,400 maximum out-of-pocket limit

The government has requested comments on these plan designs and others that should be included a safe harbor. Final regulations should provide more details on safe harbor plans that meet the 60 percent minimum value standard.

Affordability Test

The latest regulations clarify the affordability test. To avoid penalties, the employer must offer an affordable health plan that satisfies the minimum value standard. An affordable plan is one that does not cost more than 9.5 percent of an employee's household income for single coverage.

Employers were not sure how to handle wellness incentives that offer premium discounts or surcharges when they calculate affordability. If the wellness incentives or surcharges are NOT related to preventing or reducing tobacco use, the employer should assume the employee does not meet the required standard. For wellness incentives or surcharges that are related to preventing or reducing tobacco use, the employer should assume the employee does meet the required standard.

Transitional Relief

Employer plan years beginning before January 1, 2015, will be granted transitional relief for wellness-contingent plans or contributions. If an employee receives a premium tax credit because a plan fails either the minimum value or affordability tests, and the employer's plan would have passed these tests if the employee had met the wellness requirements, then an employer penalty will not apply.

This transitional relief **only applies** to wellness plans that meet the following requirements:

- The plan year must begin before January 1, 2015.
- As of May 3, 2013, the employer must express the reward or penalty in dollars or as a fraction of the total required employee contribution for coverage. If the wellness incentive is a change in cost-sharing, then they must also express that cost-sharing change in dollars or as a percentage.
- The employer plan must describe the incentives under the terms of the plan in effect on May 3, 2013.
- The employee must be eligible under the terms of the wellness program as of May 3, 2013.

If an employer qualifies for transitional relief, they may use any required premium contribution based on satisfying a wellness program requirement to determine the affordability of the plan.

Individual Premium Tax Credit

An *applicable taxpayer* whose household income for the taxable year falls between 100 percent and 400 percent of the Federal Poverty Level (FPL) may be eligible for a premium tax credit to help pay for qualified health plan coverage. Coverage must be purchased through the Exchange and the taxpayer can't be eligible for minimum essential coverage.

The premium assistance amount the taxpayer receives is based on the number of family members in the household and the FPL. Annual premium tax credits also depend on the number of coverage months in the year. A coverage month is any month that a taxpayer or family member has paid Qualified Health Plan (QHP) coverage. The taxpayer must pay the premium or use an advanced premium tax credit to pay for coverage. A month is not a coverage month for anyone **eligible** for other minimum essential coverage.

If the other minimum essential coverage is employer-sponsored coverage, it is treated as minimum essential coverage only if it offers the minimum value and is affordable. This means if an employer offers an employee coverage that is not affordable or does not meet minimum value, the employee may be eligible for subsidized coverage through the Exchange.

Health care reform offers a special approach for employers that require employees to enroll in a plan that does not provide minimum value or is unaffordable. First, an employer can avoid issues when automatic enrollment is required by allowing employees to decline or terminate coverage. Employers who do not allow an employee to opt out will be treated as though they did not offer coverage. The employee could then obtain subsidized coverage in the Exchange. If an employee does obtain subsidized coverage in the Exchange, the employer must pay the $3,000 penalty. In addition, the government will treat these employer arrangements as impermissible interference with an employee's ability to access premium credits.

Premium credits are based on the applicable benchmark plan. This plan would be the second-lowest-cost silver plan in the rating area where the taxpayer resides.

Anyone enrolling in continuation coverage required under state or federal law will be considered eligible for minimum essential coverage only for the months the person is enrolled. This guideline applies only to former employees. The proposed regulations add a similar rule for health coverage offered to retired employees. Anyone eligible for retiree coverage is treated as having minimum essential coverage only for the months the retiree is enrolled in retiree coverage.

The rules also explain coverage months for newborn and newly adopted children. In order for a month to be considered a coverage month, a taxpayer needs to be covered as of the first of the month. Plans commonly cover newborns as of the date of birth and cover adopted children as of the date of the adoption. Under the proposed regulations newborn and adopted children are treated as enrolled for the full coverage month if they are added to coverage when they are initially eligible. Taxpayers will be eligible for the tax credit for the full month when a new child is added.

If a taxpayer ends coverage mid-month, premium tax credits will be pro-rated for the part of the month the taxpayer was covered.

The proposed regulations confirm that premium tax credits apply only to the portion of the QHP premium allocated to essential health benefits. Premiums allocated to any benefits that are not essential health benefits need to be disregarded.

The proposed regulations also change the requirement to file a tax return in order to be eligible for premium tax credits. Initial regulations required the tax return to be filed on or before April 15. The proposed regulations require taxpayers to file their tax returns on or before the due date of the return (including extensions).

Concluding Thoughts

The IRS could not have made the approach to calculating minimum value and affordability more complex. For affordability purposes, the employer can add any incentives to the premium for tobacco-related wellness initiatives. For non-tobacco wellness plans, the employer must assume the employee fails to meet the participation or health standard. If this is the case, that premium incentive cannot be included when calculating affordability.

Employers with wellness-driven plan designs may find meeting the minimum value a challenge. They would most likely need to use the standard level of benefits.

The IRS intends to offer plan designs employers can use as a safe harbor for determining minimum value. However, the IRS should include typical employer cost-sharing to help employers determine minimum value safe harbors. For example, including office and emergency room copays would help employers compare plans. The IRS also may want to include more specifics on the prescription drug benefit. Many plans have tiered copay structures, rather than applying prescription expenses to the deductible.

The government will continue to clarify the many complicated health reform requirements.