General Board
Pension and Health Benefits

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Health Care Reform—Defining "Minimum Value" For Employer Coverage

On May 3, 2013, the Internal Revenue Service (IRS) published a **proposed rule** intended to further clarify the definition of "minimum value" for employer group health plans. The rule also further clarifies "affordability" of employer-provided health coverage for the purpose of determining eligibility for the premium tax credits (federal assistance for low- and middle-income individuals) toward the purchase of health insurance coverage through the health insurance exchanges (Exchanges) established by the Patient Protection and Affordable Care Act (PPACA or ACA).

With regard to the ACA, definitions of minimum value and affordability are essential to determining whether an individual qualifies for a premium tax credit (PTC), i.e., federal assistance toward the purchase of health insurance from an ACA Exchange. In most cases, individuals who are offered health insurance coverage by their employer *will not qualify* for a PTC. However, individuals who are offered health insurance through their employer *may be eligible* for a PTC if either of the following occurs:

- If the employer coverage does not provide "minimum value" (MV) (based on ACA guidelines: generally, coverage at the 60% "bronze" level); or
- If the employer coverage is not "affordable" (based on ACA guidelines).

An employer offering a health plan that fails to meet minimum value or affordability standards may also be assessed a penalty under the ACA's "pay or play" rule if one or more of its employees receives a PTC for coverage through an Exchange and the employer has 50 or more full-time equivalent employees. (Affordability under ACA is explained in greater detail **here**.)

The **proposed rule** issued May 3 by the IRS complements **MV regulations** from the Department of Health and Human Services (HHS) published in February 2013.

Minimum Value and UMC Health Plans

All medical and prescription drug benefit options under HealthFlex will satisfy the minimum value standard in 2014.

Most other health plans offered by United Methodist Church annual conferences should satisfy the MV requirement, as most are more generous than a 60% ("bronze") plan. Nonetheless, plan sponsors and participating employers will be required to disclose to participants whether or not their plans provide MV. Therefore, plan sponsors should ensure that their plans provide MV using one of the calculation methods described below.

Plan sponsors will need to disclose whether their health plans provide minimum value in 2014 on the revised summary of benefits and coverage (SBC) for 2014. You can read more about SBC updates **here**. Participating employers in annual conference plans and employer plan sponsors of their own church health plans will need to disclose whether the plan provides MV on the required Exchange Notice that must be shared with all employees no later than October 1, 2013. You can read more about the Exchange Notice requirement **here**.

Calculating Minimum Value

The ACA provides that an employer group health plan fails to offer minimum value if "the plan's share of the total allowed costs of benefits provided under the plan is *less than 60 percent* of such costs." This is a determination made by actuaries, using HHS **rules** for determining *actuarial value*, explained **here**. The HHS rules provide that the MV of a group health plan shall be calculated by determining its anticipated covered medical spending for essential health benefits (EHB).

HHS rules offer several options for plan sponsors to calculate MV:

- Plan sponsors may use the Minimum Value Calculator found **here** and explained **here**.
- Plan sponsors may apply one of the safe harbor plan designs developed by HHS and the IRS, described below;
- For plans with nonstandard designs or features, plan sponsors may provide an actuarial certification from a member of the American Academy of Actuaries; or
- Plan sponsors of plans in the fully insured small group market may also meet MV requirements if they provide a bronze level plan (60% coverage) or better.

The HHS approach for calculating minimum value has some challenges, in that most group health plans, such as annual conference health plans, are not required to cover the EHBs. However, plan sponsors can rely on one of the four methods listed above. The easiest method is likely to be the first option: using the Minimum Value Calculator. The MV Calculator is currently in proposed form, but will likely be finalized soon for plan sponsors to rely upon.

Safe Harbor Plan Designs

The proposed rule suggests three safe harbors for determining MV for plans that cover all benefits included in the MV calculator:

1. $3,500 integrated medical and prescription drug deductible
   80% cost-sharing
   $5,000 maximum out-of-pocket limit

2. $4,500 integrated medical and prescription drug deductible
   70% cost-sharing
   $6,400 maximum out-of-pocket limit
   $500 employer contribution to a health savings account

3. $3,500 medical deductible
   $0 prescription drug deductible
   60% medical cost-sharing
   $10/$20/$50 co-payment tiered prescription drug plan
   75% co-insurance for specialty drugs

HSA and HRA Contributions

The proposed rule also addresses how employer contributions toward health savings accounts (HSAs) or health reimbursement arrangements (HRAs) should count toward minimum value. HHS and IRS rules provide that all employer contributions for the current plan year to an HSA should be taken into account in determining MV. Current-year employer contributions to HRAs can be counted toward MV if the HRA: (i) is integrated into a group health plan, (ii) can only be used for cost-sharing (e.g., for paying deductibles and co-payments), and (iii) cannot be used for premiums.

Wellness Programs

The proposal also addresses how reduced cost-sharing under wellness programs should be treated in calculating minimum value; for example, when a plan offers a lower deductible for completing a risk assessment. Recognizing that "certain individuals inevitably will face barriers to participation [in wellness

programs] and fail to qualify for rewards," the proposed rule *does not count* reduced cost-sharing as part of wellness programs toward MV calculations.

Under this interpretation, all employees are treated as having failed to qualify for the more favorable cost-sharing design with respect to the wellness program (e.g., all employees are assumed to have the *higher* deductible). However, there is one exception: MV may be calculated assuming that every individual who is subject to a nondiscriminatory program aimed at the prevention or reduction of tobacco use satisfies the program (meaning that the plan will be able to treat those who fail to meet the smoking cessation program as though they had met the program for MV purposes).

Additional Clarification of Affordability

Under the ACA, employees may be eligible for premium tax credits if the employment-based coverage they are offered is not "affordable," i.e., the employee's required contribution or share of premium costs the employee more than 9.5% of his or her household income. The affordability rule is discussed in detail **here**. The newly issued **proposed rule** addresses questions as to how employer contributions to an HRA are treated and how wellness incentives impacting an employee's share of the premium is treated when calculating affordability. The proposed rule provides that:

- Amounts made newly available under an HRA for a current plan year that can be used (i) only for premium payment or, (ii) for either premiums or for cost-sharing reduction, *will be considered available to the employee and thereby increase the affordability of an employee's coverage (reducing the cost to the employee).* HRA contributions that are available for premiums will be treated as reducing the cost of coverage for an employee.
- Conversely, wellness incentives that reduce premiums (e.g., a lower premium for those who complete a risk assessment) generally *will not be considered as increasing affordability*. In essence, for determining affordability, employees will be treated as having failed to qualify for reduced premiums for completing wellness activities. Presumably a similar treatment would apply to negative incentives, e.g., a higher premium for failing to complete a risk assessment—all employees would be treated as having the higher premium. An exception applies regarding nondiscriminatory wellness programs related to tobacco use.

The affordability rule has a second application under the **individual mandate**. The preamble to the proposed rule further states that for purposes of the individual mandate penalty, health coverage *will not be considered affordable* if the coverage would not be affordable (i.e., would cost more than 8% of household income) if a reduction in premium for participation in a wellness program was not available. Under this circumstance, the individual mandate penalty for not having coverage would *not* apply because the plan did not meet the affordability standard.

Note: The ACA rules for what is "affordable" differ between eligibility for premium tax credits (PTCs) and avoiding the individual mandate penalty:

- *Individual mandate affordability*: individual's premium cost must be less than **8%** of household income;
- *PTC eligibility affordability*: participant's premium cost of employer-provided coverage must be less than **9.5%** of household income.

Moreover, *for 2014*, if an employee receives a PTC because an employer health plan is not affordable, but that employer coverage would have been affordable had the employee satisfied the requirements of a wellness program that was in effect on or before May 3, 2013 (i.e., if the employee would have had a lower premium if he or she had complied with the wellness program), the employer will *not* be subject to the employer penalty under the "pay or play" rule, if it is a large employer. In other words, if an employer has an existing wellness program that reduces premiums for certain employees, the employer will not be punished with a penalty for 2014 under the "pay or play" rule if not meeting the wellness incentive causes coverage to be unaffordable for some employees because those employees did not comply with the wellness program.

Retiree Coverage Clarification

Another important clarification in the **proposed rule** involves retiree health coverage. The rule explains that former employees eligible for retiree coverage are excluded from eligibility for PTCs only if they enroll in such coverage. This allows a retiree who is eligible for coverage through his or her annual conference or former employer to postpone enrolling in that coverage and enroll in a health plan through an Exchange instead, and possibly qualify for a PTC. Some retiree plans have rules that do not allow postponement of enrollment, i.e., they require the retiree to enroll upon retirement and remain covered.

> ***UMC Implication***
> Annual conferences and other plan sponsors of health plans that cover pre-Medicare retirees may want to consider amending their rules to add some flexibility as a result of this clarification. Pre-Medicare retirees (under age 65) could seek Exchange coverage for years between their early retirement and the date they become eligible for Medicare. When retirees become Medicare-eligible, the annual conference or former employer could then enroll them in a Medicare supplement plan for retirees or a Medicare exchange.

Questions and Information

If you have questions or would like additional information, please send your inquiries to **healthcarereform@gbophb.org**. General information about health care reform is available from the federal government at **www.healthcare.gov**.
