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Health Reform

Guidance Released on Affordability and Minimum Value

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In order to receive a subsidy in the Health Insurance Marketplace (formerly referred to as the Exchange), generally an individual must not be eligible for affordable coverage under an eligible employer sponsored plan that provides minimum value. Additionally, large employers looking to avoid penalty exposure must offer all full-time employees (and their dependents) affordable coverage that meets minimum value. Although final regulations were published back in February, further clarification was needed on the health benefits considered in determining the share of benefit costs paid by a plan.

The IRS recently issued a proposed rule that addresses a number of important affordability and minimum value issues, discussed briefly below.

Affordability

Affordable coverage generally means that the employee's cost for self-only coverage does not exceed 9.5% of the employee's household income. Under available safe harbors, employers may determine affordable coverage based on the following:

- The employee's W-2 wages as determined at the end of the year on an employee-by-employee basis.
- The employee's computed monthly wages (for hourly employees, the employee's hourly rate of pay multiplied by 130 hours; for salaried employees, the monthly salary).
- Federal poverty level for a single individual.

HRAs and HSAs

The proposed regulations provide that HSA funds may not be taken into account in determining whether the employer's coverage is affordable since HSA funds generally cannot be used to reduce premium costs in a group health plan. HRA contributions for a current year, on the other hand, may in some cases be included in the affordability determination. Amounts newly made available under an HRA that is integrated with an eligible employer sponsored plan for the current plan year are taken into account in determining affordability to the extent an employee may use the funds to pay premiums toward the employee's required contribution. However, this is not a common plan design -- for a variety of reasons, it is more common for the HRA funds to only

reimburse cost-sharing under the employer-provided group medical plan than to allow for premium reimbursement through the HRA.

Wellness Plans

The proposed regulations provide that affordability of an employer sponsored plan is determined by assuming that each employee fails to satisfy the requirements of a wellness program, except the requirements of a nondiscriminatory wellness program related to tobacco use. So, if an employer offers a wellness incentive under a health plan that will reduce an employee's share of the premium costs because the employee is either a non-smoker or completes a reasonable alternative program (e.g., a smoking cessation course), affordability would be determined based on the premium that includes this tobacco-related wellness incentive. But, if a plan has a wellness incentive that will reduce an employee's share of the premium cost because the employees maintains a Body Mass Index below a certain level, affordability would no t be determined based on the premium that includes the wellness discount. Only incentives related to tobacco use may be counted toward the premium mount used to determine affordability.

Minimum Value

An eligible employer sponsored plan provides minimum value only if the plan's share of the total allowed costs of benefits provided to an employee (the minimum value percentage) is at least 60%. There are several methods for determining minimum value:

- the minimum value calculator (http://cciio.cms.gov/resources/regulations/index.html#pm);
- a safe harbor;
- actuarial certification; and
- for small groups, a metal level (bronze, silver, gold or platinum).

In the preamble to the proposed regulations, the guidance proposes certain designs as minimum value safe harbors if the plans cover all of the benefits included in the minimum value calculator. It is anticipated that future guidance will provide that the safe harbors are examples of plan designs that would clearly satisfy the 60% threshold if measured using

the minimum value calculator. This would be a simple way for a typical plan to determine whether it meets the minimum value threshold without having to utilize the minimum value calculator. The following designs were proposed

- A plan with a $3,500 integrated medical and drug deductible, 80% 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% plan cost-sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to an HSA.
- A plan with a $3,500 medical deductible, $0 drug deductible, 60% medical plan expense cost-sharing, 75% plan drug cost-sharing, $6,400 maximum out-of-pocket limit, and drug copays of $10/$20/$50 with 75% coinsurance for specialty drugs.

These designs will need to be adjusted for non-grandfathered plans as the maximum out-of-pocket amount for self-only coverage will be $6,350 in 2014, a limit announced after issuance of these proposed regulations.

HSAs and HRAs

The proposed regulations provide that employer contributions for the current plan year to HSAs that are offered with an eligible employer sponsored plan are taken into account for that plan year toward the plan's minimum value percentage. Similarly, HRA contributions for a current year may, in some cases, be included in the minimum value determination. Amounts newly made available for the current plan year in an HRA that is integrated with an eligible employer sponsored plan are taken into account for that plan year towards the plan's minimum value percentage provided the HRA funds may only be used to reduced cost-sharing for covered medical expenses (and not toward premiums).

Wellness Plans

The proposed regulations provide that wellness programs that provide incentives that affect deductibles, coinsurance, copays, or other cost-sharing provisions based on satisfaction of certain wellness activities can be taken into account in determining minimum value, to the extent the incentives relate to tobacco use. However, wellness program incentives that do not relate to tobacco use are treated as "not earned" and not taken into account in determining minimum value.

Transition Relief

For plan years beginning before January 1, 2015, affordability (with respect to premium contributions) and minimum value (with respect to cost-sharing) can be determined as if the employee satisfied the requirement of any wellness program, including one unrelated to tobacco use as follows:

- To the extent of the reward as of May 3, 2013, expressed either as a dollar amount or a fraction of the total required employee contribution to the premium (or the employee cost-sharing if applicable);
- Under the terms of the wellness program as in effect on May 3, 2013; and
- With respect to an employee who is in a category or employees eligible under the terms of the wellness programs as in effect on May 3, 2013 (regardless of whether the employee was hired before or after that date).

It appears the transition relief does not apply to any new wellness incentive, increased wellness incentive, or a more difficult standard to obtain the reward in effect after May 3, 2013. For example, a group health plan that increases standards-based wellness incentives, as permitted by health care reform, from 20% to 30% of the premium for the first plan year that begins on or after January 1, 2014 will not be able to use this transition relief. Thus, affordability and/or minimum value will be determined based solely on incentives related to tobacco use, and the plan must treat any other incentive as unearned for affordability/minimum value purposes.