Washington Council Ernst & Young

Legislative Alert

May 1, 2013

Administration Releases Proposed Rules on Standards for Employer-Sponsored Coverage Under the Health Care Law, Applications for Exchange Coverage

The Department of the Treasury and the IRS late yesterday (April 30, 2013) released a notice of proposed rulemaking under Internal Revenue Code section 36B on the application of coverage standards for employer-sponsored coverage under the Affordable Care Act (ACA). Importantly, the proposed rules clarify how employer contributions to health savings accounts (HSAs), health reimbursement accounts (HRAs) and wellness programs will be treated under the ACA's affordability and minimum value (MV) standards.

Separately, the Department of Health and Human Services (HHS) yesterday issued final applications that individuals will submit to health insurance Exchanges. The forms will be used to determine eligibility for premium assistance tax credits for Exchange coverage, as well as for coverage through Medicaid or CHIP. HHS issued applications to be used by:

- Families
- Single adults whose employers do not offer health coverage and who are seeking premium assistance tax credits or coverage through Medicaid/CHIP
- Individuals applying for Exchange coverage without financial assistance

Notably, the application for families includes an appendix focused on "Health Coverage from Jobs" to help Exchanges determine whether the employee has access to employer coverage, determine eligibility for tax credits, and notify an employer if a full-time employee is determined to be eligible for a tax credit. The "Employer Information" section of the appendix requests the employer name, identification number, address, phone number, and contact information for someone who can be contacted about employee health coverage for the applicant. The appendix also requests information about the employee premium for self-only coverage and whether the plan meets the law's minimum value standard.

Applications can be submitted online, by phone or in paper form when open enrollment begins October 1, 2013.

The proposed rules are scheduled to be published in the May 3 Federal Register and are subject to a 60-day comment period. Key provisions of the proposed rule for employers are highlighted below.

Determining MV

To meet the ACA's minimum value standard, an employer-sponsored plan's share of the total allowed cost of benefits provided under the plan must be at least 60% of such costs. The proposed rules restate that employer-sponsored self-insured and insured large group plans do not have to cover every category included in the law's essential health benefits (EHB) package or conform their plans to an EHB benchmark that applies to qualified health plans sold in Exchanges.

The proposed rules also state that in determining MV, taxpayers must use the MV calculator made available by HHS and IRS to measure standard plan features (unless a safe harbor applies- *see below*), while providing that the percentage may be adjusted based on an actuarial analysis of plan features that are outside the parameters of the calculator. Under the proposed rules, plans with non-standard features that cannot determine MV using the calculator a safe harbor may obtain an actuarial certification from a member of the American Academy of Actuaries.

In a point of distinction from qualified health plans available on Exchanges, the proposed rules do not provide for a de minimis exception to the 60% MV standard.

MV safe harbors

The regulations propose the following plan designs as safe harbors for determining MV if the plans cover all of the benefits (physician and mid-level practitioner care; hospital and emergency room services; pharmacy benefits; and laboratory and imaging services) included in the MV Calculator:

1. 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;
2. 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; and
3. A plan with a $3,500 medical deductible, $0 drug deductible, 60% plan medical expense cost-sharing, 75% 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% 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.

Treatment of HSAs and HRAs for MV

Consistent with rules issued by HHS in November 2012, the proposed rules provide that all employer contributions 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. In addition, the proposed rule states that 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 if the amounts may be used only for cost-sharing and may not be used to pay insurance premiums. According to the proposed rule, anticipated regulations will provide that whether an HRA is integrated with an employer-sponsored plan will be determined under rules generally prohibiting lifetime or annual limits on benefits (Public Health Service Act §2711 as created by ACA §1001).

Treatment of HRAs for affordability

Under the ACA, employer-sponsored coverage is considered affordable if the employee's share of premium for self-only coverage does not exceed 9.5% of the employee's household income. The proposed regulations provide that 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 only in determining affordability if the employee may use the amounts only for premiums or may choose to use the amounts for either premiums or cost-sharing. This provision is intended to prevent double counting the HRA amounts when assessing MV and affordability of eligible employer-sponsored coverage.

Treatment of wellness programs for MV

The proposed ruled state 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.

Under a notice of proposed rulemaking jointly issued in November by the IRS, the Department of Labor's Employee Benefits Security Administration (EBSA) and HHS' Centers for Medicare and Medicaid Services (CMS), the maximum permissible reward under a health-contingent wellness program will increase from 20% to 30% of the cost of health coverage. The agencies also proposed increasing the maximum reward to as much as 50% of the cost of health coverage for programs designed to prevent or reduce tobacco use.

Treatment of wellness programs for affordability

Similarly, the proposed rule does not assess affordability based on the premium reduction associated with satisfying the requirements of a wellness program, except the requirements of a nondiscriminatory wellness programs designed to prevent or reduce tobacco use. Thus, the affordability of a plan that charges a higher initial premium for tobacco users will be determined based on the premium that is charged to non-tobacco users, or tobacco users who complete the related wellness program, such as attending smoking cessation classes.

Transition relief for wellness programs for affordability

The proposed rule provides for transition relief solely for purposes of applying section 4980H and solely for plan years of an employer's group health plan beginning before January 1, 2015. With some qualifications (listed below), an employer will not be subject to an assessable payment under section 4980H(b) for an employee who received a premium tax credit because the offer of coverage was not affordable or did not satisfy MV, if the offer of coverage to the employee under the employer's group health plan would have been affordable or would have satisfied MV based on the total required employee premium and cost-sharing for that group

health plan that would have applied to the employee if the employee satisfied the requirements of any wellness program, including a wellness program with requirements unrelated to tobacco use. The transition relief applies only:

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

Any required employee contribution to premium determined based upon assumed satisfaction of the requirements of a wellness program available under this transition relief may be applied to the use of an affordability safe harbor provided in the proposed regulations under section 4980H.

More information

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