



VCU Medical Center

Office of Health Innovation

Proposed Rule: Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit

Description: These proposed regulations affect individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges) and claim the premium tax credit, and Exchanges that make qualified health plans available to individuals and employers. These proposed regulations also provide guidance on determining whether health coverage under an eligible employer-sponsored plan provides minimum value and affect employers that offer health coverage and their employees.

Major Provisions

Minimum Value

The Minimum Value (MV) percentage is determined by dividing the cost of certain benefits (described in paragraph b.) the plan would pay for a standard population by the total cost of certain benefits 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.

- 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 MV.
- **Health Savings Accounts**
 - All amounts contributed by an employer 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.
- **Health Reimbursements Arrangements**
 - 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.
 - 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.
 - 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.
- **Cost-Sharing**

- A plan's share of costs for MV purposes is determined without regard to reduced cost-sharing available under a nondiscriminatory wellness program.
- 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 relating to prevention or reduction of tobacco use.
- **Methods for Determining Minimum Value**
 - Taxpayers may determine whether a plan provides MV by using the MV Calculator made available by HHS and the IRS.
 - Taxpayers must use the MV Calculator to measure standard plan features (unless a safe harbor applies), but the percentage may be adjusted based on an actuarial analysis of plan features that are outside the parameters of the calculator.
- **Safe Harbors**
 - It is expected that future HHS guidance will provide that the safe harbors are examples of plan designs that clearly would satisfy the 60 percent threshold if measured using the MV Calculator.
 - The safe harbors are intended to provide an easy way for sponsors of typical employer-sponsored group health plans to determine whether a plan meets the MV threshold without having to use the MV Calculator.
 - Plan designs meeting the following specifications are proposed as safe harbors for determining MV if the plans cover all of the benefits included in the MV Calculator:
 - 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;
 - 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 an HSA; and
 - 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**
 - Plans with nonstandard features that cannot determine MV using the MV Calculator or a safe harbor are required to use the actuarial certification method.
 - The actuary must be a member of the American Academy of Actuaries and must perform the analysis in accordance with generally accepted actuarial principles and methodologies and any additional standards that subsequent guidance requires.

Modified Gross Income

The term *household income* means the modified adjusted gross income of the taxpayer plus the modified adjusted gross income of all members of the taxpayer's family required to file a tax return under section 1 for the taxable year.

- Previous regulations provide that the determination of whether a family member is required to file a return is made without regard to section 1(g)(7). Under section 1(g)(7), a parent may, if certain requirements are met, elect to include in the parent's gross income, the gross income of his or her child. If the parent makes the election, the child is treated as having no gross income for the taxable year.
 - The proposed regulations remove “without regard to section 1(g)(7)” and clarify that if a parent makes an election under section 1(g)(7), household income includes the child's gross income included on the parent's return and the child is treated as having no gross income.

Retiree Coverage

Previous regulations provide that an individual who may enroll in continuation coverage required under Federal law or a State law that provides comparable continuation coverage is eligible for minimum essential coverage only for months that the individual is enrolled in the coverage.

- These proposed regulations apply this rule to former employees only.
- Active employees eligible for continuation coverage as a result of reduced hours should be subject to the same rules for eligibility of affordable employer-sponsored coverage offering MV as other active employees.
- The proposed regulations add a comparable rule for health coverage offered to retired employees (retiree coverage). Accordingly, an individual who may enroll in retiree coverage is eligible for minimum essential coverage under the coverage only for the months the individual is enrolled in the coverage.

Coverage Month

- **Coverage Month for Newborns and New Adoptees:**
 - Under current rules, a month is a coverage month for an individual only if, as of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange.
 - The proposed regulations provide that a child enrolled in a qualified health plan in the month of the child's birth, adoption, or placement with the taxpayer for adoption or in foster care, is treated as enrolled as of the first day of the month.
- **Adjusted Monthly Premium for Family Members Enrolled for Less Than a Full Month**
 - The proposed regulations provide that the adjusted monthly premium is determined as if all members of the coverage family for that month were enrolled in a qualified health plan for the entire month.
- **Adjusted Monthly Premium for Family Members Enrolled for Less than a Full Month**

- The final regulations do not address the computation of the premium assistance amount if coverage under a qualified health plan is terminated during the month.
- The proposed regulations provide that when coverage under a qualified health plan is terminated before the last day of a month and, as a result, the issuer reduces or refunds a portion of the monthly premium the premium assistance amount for the month is prorated based on the number of days of coverage in the month.

Clarifications and Corrections

- **Family Members Residing at Different Locations**
 - Previous regulations reserved rules on determining the premium for the applicable benchmark plan if family members are geographically separated and enroll in separate qualified health plans.
 - The proposed regulations provide that the premium for the applicable benchmark plan in this situation is the sum of the premiums for the applicable benchmark plans for each group of family members residing in a different State.
- **Correction to Applicable Percentage Table**
 - The applicable percentage table in the current regulations erroneously states that the 9.5 percentage applies only to taxpayers whose household income is less than 400 percent of the FPL.
 - The proposed regulations clarify that the 9.5 percentage applies to taxpayers whose household income is not more than 400 percent of the FPL.
- **Additional Benefits and Applicable Benchmark Plan**
 - The proposed regulations provide that premiums are allocated to additional benefits before determining the applicable benchmark plan.
 - Only essential health benefits are considered in determining the applicable benchmark plan, consistent with the requirement that only essential health benefits are considered in determining the premium assistance amount.
- **Requirement To File a Return To Reconcile Advance Credit Payments**
 - Current regulations provide that a taxpayer who receives advance credit payments must file an income tax return for that taxable year on or before the fifteenth day of the fourth month following the close of the taxable year.
 - Under the proposed regulations, a taxpayer who receives advance credit payments must file an income tax return on or before the due date for the return (including extensions).