Pay or Play Mandate - How Large & Self-Funded Employers Can Satisfy Minimum Value Requirements

By Bill Balek, Director of Legislative Affairs, ISSA (April 2, 2013)

The following is part of our series of articles intended to help guide employers through their new obligations under the health care reform laws and related guidance. Previous articles on health care reform have appeared in the January and February issues of the ISSA Legislative and Regulatory Update.

A major emphasis of health care reform is reducing the number of uninsured individuals, and the employer "pay or play" mandate is one of several new laws aimed at expanding coverage. Although this new law does not require you, as an employer, to provide health coverage to your employees, beginning in January 2014 if you are a large employer you must choose to "play" (offer "minimum essential coverage" to all of your full-time employees) or "pay" (owe a potential excise tax if you do not offer "minimum essential coverage"). As a general rule, the "pay or play" mandate applies to you for a calendar month if you employed an average of at least 50 full-time equivalent employees (FTEs) on business days in the prior calendar year. For a more detailed explanation of what companies are subject to the "pay or play" mandate, see our prior article in the January issue of the ISSA Legislative and Regulatory Update here.

If you decide you want to "play," the key is to make sure your employer-sponsored group health plan is providing "minimum essential coverage." But what does this mean? We know that it, at a minimum, requires that coverage is "affordable" and provides "minimum value." We also know that affordability generally means that the employee's share of the premium for self-only coverage does not exceed 9.5% of the employee's "household" income (see our prior article in the January issue of the LARU). But until recently we did not have much guidance on how minimum value would be calculated. If you are a non-calendar year employer, you may have already begun negotiating your new offerings for the plan year beginning in 2013 (which will cross into 2014 when the "pay or play" rules taken effect). As a result, you are likely looking for clarity so that you can be sure that the policies and plan terms you put in place now will not have to be changed mid-plan year in order to satisfy minimum value requirements.

There is some good news - the Department of Health and Human Services (HHS) has issued proposed rules that shed some light on the choices employers will have for showing that minimum value has been met. These rules are different depending on whether the employer is (1)

purchasing insurance in the small-group market, or (2) purchasing insurance in the large group market or designing coverage for a self-insured plan. This alert is Part 1 and summarizes the proposed rules as they apply to employers purchasing insurance in the large group market or designing coverage for a self-insured plan.

Minimum Value: Minimum value generally means that the percentage of health care costs, on average, that your plan is expected to cover must be at least 60% (i.e. the plan has an actuarial value of at least 60%). The proposed rules provide the following insight into the minimum value determination:

(A) You may choose between 3 methodologies:

- *Minimum value calculator* – the calculator is to be made available by HHS and the IRS and allows you to enter information about the plan's cost sharing to determine whether the plan provides minimum value. It will be similar in design to the actuarial value (AV) calculator used for individual and small-group insurance but instead of a "benchmark plan" in each state, the calculator will be based on continuance tables and a standard population reflecting claims data of typical self-insured employer plans (which is expected to result in a similar or higher actuarial value than the AV calculator for the same benefit design). If your plan uses the minimum value calculator and offers an essential health benefit outside of the parameters of the calculation, you would be permitted to have an actuary determine the value of that benefit (in a manner similar to option #3 below).

- *Safe harbor checklist of required benefits* – this option will offer "an array of design-based safe harbors" published by HHS and the IRS. Each checklist will describe the cost-sharing attributes of a plan in 4 core categories of benefits and services – physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits and laboratory and imaging services.

- *Independent actuarial certification* – this option is available only if your plan contains non-standard features that are not suitable for the calculator and do not fit a safe harbor checklist. An actuary who is a member of the American Academy of Actuaries would certify, based on your plan's benefits and coverage data and standard population, utilization and pricing tables, that your plan provides minimum value.

(B) Minimum value will be determined using a standard population that is based upon large self-insured group health plans.

(C) Employer contributions to an HSA or HRA will count toward minimum value.

(D) Your plan is not required to offer all categories of essential health benefits (EHBs) or conform to any of the EHB benchmarks - although EHBs are allowed to be taken into account in determining minimum value.

(E) Annual cost-sharing limits do not apply if you purchase insurance in the large group market or sponsor a self-insured plan - HHS clarified that such limits only apply to individual insurance and insurance in the small group market.

Unfortunately, while the recent guidance provides you some roadmap of the steps you will need to take to show that your plan is providing minimum value, there are still many details that we need and do not know. For example, what will the minimum calculator look like? What will the standard population look like? How much flexibility will be given to actuaries in their determinations? We look forward to additional, detailed guidance on these and other open questions on large employer and self-insured plan minimum value.