SEYFARTH SHAW

Health Care Reform Management Alert Series

Agencies Close Loopholes, Limiting Employers' Health Coverage Options in 2015 and Beyond

Issue 88

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This is the eighty-eighth issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series). This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

During the first week of November, the DOL, IRS and HHS issued a series of informal notices and FAQs potentially closing the door on a number of creative compliance strategies that had emerged to tackle the employer mandate concern. The agencies also delayed several key November deadlines, as described in greater detail below.

Minimum Value Plans Must Include In-Patient Hospitalization/Physician Services

Strategy: Beginning in 2015, large employers must offer an "affordable" plan that provides "minimum value" to full-time employees and their dependents in order to avoid a penalty. Minimum value is primarily determined through use of the IRS/HHS MV Calculator. As self-funded and large group fully-insured plans are not required to cover all essential health benefits, the MV Calculator permitted users to "deselect" certain of these essential health benefits. This allowed a user to produce a minimum value result through a plan that excluded coverage for hospitalization or physician services. The resulting plan insulated the employer from the employer mandate penalty, but also potentially disqualified an employee from being able to access a premium tax credit or subsidy through the purchase of a plan on the Health Insurance Marketplace.

Agency Response: Apparently unhappy with this result, on November 4, the IRS issued Notice 2014-69, effectively limiting the "minimum value" label to plans that include in-patient hospitalization and physician services. The IRS warned that it intends to issue regulations, to be finalized on or around March 1, 2015, that will require plans to include in-patient hospitalization/physician services in order to meet the minimum value standard. These regulations will be effective immediately, as opposed to having a delayed effective date. A non-hospitalization/physician services plan can still be deemed minimum value through the end of the plan year beginning no later than March 1, 2015, if:

- The employer has entered into a binding written commitment to adopt, or has begun enrolling employees in, a plan excluding hospitalization/physician services prior to November 4, 2014 based on the employer's reliance on the MV Calculator;
- The employer does not state or imply that enrollment in the plan would render the employee ineligible for a premium tax credit on the exchanges (and the employer corrects any prior disclosures suggesting as much).

Commentary: The IRS has been publicly discouraging use of non-hospitalization/physician services plans for months leading up to the issuance of Notice 2014-69, and the timing of the release (election day) was likely no coincidence. The only unanswered question was whether the IRS would "grandfather" plans that had already adopted this approach. It appears employers who got in the door before election day will receive a free pass for a year before being forced to expand coverage or explore other options in 2016. It also appears that the IRS still hopes to make a premium tax credit or subsidy available to employees offered such a MV plan this year.

It remains to be seen how the MV Calculator will be revised, and how much coverage plans will be required to provide for hospitalization/physician services.

Plans/Employers May Not Shift High-Cost Claimants to the Marketplaces

Strategy: The ACA's ban on pre-existing condition exclusions and creation of the Health Insurance Marketplaces have created a new, previously unavailable, avenue for individuals with chronic, high-cost conditions to obtain coverage. Interestingly, unlike other public health care programs (e.g., Medicare, state high-risk health pools), the ACA did not contain an anti-dumping provision prohibiting employers from shifting or incentivizing their high-cost claimants to the Marketplaces. While HIPAA nondiscrimination rules prohibit employers from discriminating against individuals based on health status, there is no prohibition on "benign" discrimination (i.e., discriminating in favor of high-cost claimants). As such, many employers were considering a strategy that generally involved offering high-cost claimants a significant lump sum payment if those individuals were willing to voluntarily drop the employer's coverage and instead obtain a policy through the Marketplace.

Agency Response: The agencies issued a series of FAQs on November 6, opining that this sort of incentive does not constitute benign discrimination and instead violates HIPAA. Specifically, the agencies suggested that if an employer charges all employees $2,500 for health insurance, but offers one individual $10,000 to decline coverage, it would effectively cost that individual $12,500 to accept health insurance coverage rather than $2,500. Further, the agencies suggested this sort of arrangement has the potential to violate cafeteria plan nondiscrimination rules. See Q2 at *http://www.dol.gov/ebsa/faqs/faq-aca22.html*.

Commentary: This strategy has been viewed with unease because it involves moving a sick individual from the employer's plan to the public Marketplace. That alone doesn't make it illegal though. The agencies had to stretch existing guidance to discourage this practice, and we view this as a tortured interpretation of the HIPAA nondiscrimination rules.

No Pre or Post-Tax Payment Plans

Strategy: Certain employers were offering their employees and former employees pre-tax or post-tax reimbursement for premiums and/or expenses incurred for individual insurance policies.

Agency Response: The agencies view this as a prohibition on the ACA's (1) prohibition on lifetime or annual dollar limits, and (2) preventive service mandate. These types of reimbursement arrangements constitute group health plans and, as such, are subject to the ACA's insurance market reforms described above. See Q1 at *http://www.dol.gov/ebsa/faqs/faq-aca22.html*.

Commentary: The agency response here is a bit too broad sweeping in reimbursement arrangements that could be "excepted benefits," which are exempt from the insurance market reforms. Notably, a plan covering "less than two participants who were current employees" (e.g., a retiree-only plan) is exempt from the insurance market reforms.

Stand-Alone Section 105 Reimbursement Plans Are Prohibited

Strategy: Certain employers are coordinating with third-party vendors to locate and enroll their employees in individual policies on the applicable Marketplace where the employees can receive premium tax credits. The employer then reimburses their employees on a pre-tax basis for their premiums through a Code Section 105 reimbursement plan.

Agency Response: The agencies identified several problems with this approach, including the following:

- The arrangement would constitute a group health plan, rendering the enrolled employee ineligible for tax credits on the Marketplace.
- Pursuant to earlier DOL/IRS guidance, pre-tax reimbursement arrangements cannot be integrated with individual insurance policies. These arrangements constitute group health plans and, as a result, run afoul of the insurance market reforms (because they contain annual dollar limits and/or do not cover the required preventive services).

See Q3 at *http://www.dol.gov/ebsa/faqs/faq-aca22.html*.

Commentary: This result was not surprising following earlier DOL/IRS guidance prohibiting these types of pre-tax reimbursement arrangements. This FAQ may be directed at a particular vendor or group of vendors who were still marketing these types of products. As noted earlier, however, this guidance may be overly broad considering that excepted benefits such as retiree-only plans should not be considered subject to these rules.

HPID and TRP Fee Deadlines Delayed

Federal agencies recently delayed two key November deadlines facing plan sponsors:

- As reported in *Issue 86*, plan sponsors of large health plans were required to obtain an HPID by November 5, 2014. On October 31, HHS announced an enforcement delay, until further notice.
- As reported in *Issue 87*, plan sponsors were required to submit a plan enrollment count to HHS no later than November 17, 2014. HHS and the IRS intend to use the enrollment data to facilitate payment of the Transitional Reinsurance Program fee in January of 2015. On November 14, HHS granted an extension to file the enrollment count until 11:59 pm on December 5. The payment deadlines remain the same.

We continue to recommend that plan sponsors proceed in obtaining an HPID and submitting an enrollment count as soon as possible to avoid issues that might arise with last-minute filing.

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