Agencies Plug Several Holes in the ACA Dike

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In the years since the 2010 enactment of the Affordable Care Act ("ACA"), the agencies charged with enforcing the ACA have worried that certain responses to the law’s requirements could negatively affect the overall health insurance system. For instance, because the ACA requires insurers to issue individual health insurance coverage without regard to health status, sponsors of self-funded employer plans may be tempted to shift their high-risk employees into the individual market. But by leaving only healthier employees in the self-funded plans, this approach could result in “adverse selection” – leading to an erosion of the individual insurance market.

Taking a page from the Little Dutch Boy, these agencies have now issued a number of pieces of guidance designed to plug several holes in the ACA dike resulting from what they perceive as abusive practices by employers and their advisers. This guidance will (1) require that any plan claiming to satisfy the ACA’s “minimum-value” standard offer substantial coverage for inpatient treatment, (2) prevent employers from providing even after-tax incentives for their employees to waive coverage under an employer plan, and (3) encourage state insurance regulators to impose minimum attachment points on stop-loss policies issued to self-funded health plans.

“Minimum Value” Requires Inpatient Coverage

An employer may avoid both of the ACA’s ‘play-or-pay’ excise taxes by offering its full-time employees health coverage that is both “affordable” and of “minimum value.” For this purpose, a “minimum value” plan must be designed to pay at least 60% of the costs of “essential health benefits.” Under existing guidance, an employer may determine whether its self-funded health plan meets this “bronze” standard by entering information concerning the plan’s benefit structure into an online calculator. If that calculator reflects a value of 60% or more, the plan is deemed to provide minimum value.

In recent months, however, various third-party administrators have determined that this 60% threshold may be met by a plan that provides no coverage whatsoever for inpatient hospitalization or physician services. This can be done by providing generous co-payments, deductibles, and the like, which are apparently over-weighted by the online calculator. As a result, the actuarial cost to provide this type of coverage can be as little as half the cost of a “typical” bronze plan.

Adding to the agencies’ unhappiness with these plans is their negative impact on employees. An employee who is offered affordable coverage under a minimum-value plan is thereby ineligible to obtain a federal tax subsidy to help purchase coverage through a public Exchange. So an employee who is offered coverage under one of these plans – but who cannot afford to pay the non-subsidized premium for coverage through an Exchange – may have no effective access to coverage for inpatient services.

In Notice 2014-69, the IRS has announced steps to shut down what it calls “non-hospital/non-physician services plans.” Working with the Department of Health and Human Services, the IRS intends to issue guidance in early 2015 requiring that any minimum-value plan provide substantial coverage for inpatient hospitalization and physician services. As a result, an employer will not be able to rely on a non-hospital/non-physician services plan to avoid the second-tier play-or-pay penalty (equal to $3,000 per year for any full-time employee who waives coverage under the employer plan and obtains a federal tax subsidy to purchase coverage through a public Exchange).
The IRS Notice does grant limited “grandfather” protection for certain of these non-hospital/non-physician services plans. But this protection applies only for plan years beginning on or before March 1, 2015, and only if, by November 4, 2014, the plan sponsor either had a binding written commitment to adopt such a plan or had begun enrolling employees in such a plan. Even these grandfathered plans will have to add coverage for inpatient services in order to attain minimum-value status in later plan years.

At the same time, the IRS announced that employees who are offered coverage under one of these grandfathered non-hospital/non-physician services plans will not thereby lose their eligibility for a federal tax subsidy to purchase coverage on a public Exchange. One of the conditions attached to the grandfather protection is that a plan sponsor may not state or imply in any disclosure to its employees that the offer of coverage under the non-hospital/non-physician services plan precludes the employee from obtaining this federal premium subsidy.

Such a sponsor must also timely correct any prior disclosures to the contrary. According to the IRS, even a statement in a summary of benefits and coverage (“SBC”) that a plan provides minimum value would be considered to imply that the offer of coverage under that plan precludes an employee from obtaining a tax credit. Thus, any sponsor that chooses to maintain a grandfathered non-hospital/non-physician services plan for 2015 may need to issue a revised SBC or other notice in the immediate term.

One more point is worth noting in this connection. Some plans are not even designed to meet the 60% minimum-value standard. Rather, these “skinny plans” are intended simply to constitute “minimum essential coverage.” By offering such coverage to substantially all of its full-time employees, an employer will be shielded from the first-tier play-or-pay penalty ($2,000 per full-time employee after an offset amount). Many skinny plans offer little more than preventive care. Nonetheless, IRS officials have informally conceded that such plans do constitute minimum essential coverage. Nothing in the recent guidance would counteract that view.

**After-Tax Premium Subsidies**

As explained in our October 2013 article, the IRS made clear in Notice 2013-54 that health reimbursement arrangements (“HRAs”) may not be used to reimburse employees for the premiums they pay to purchase individual health insurance. The reasoning was that an HRA constitutes an employer health plan, subject to all of the ACA mandates, and that it simply cannot satisfy certain of those mandates. These include the prohibition on annual or lifetime limits on coverage for essential health benefits, and the requirement to provide unlimited coverage for designated “preventive-care services.”

Notice 2013-54 also created the more generic concept of an “employer payment plan,” concluding that such plans could also not make pre-tax premium reimbursements for the purchase of individual health insurance. The Notice seemed to leave the door open, however, to an employer’s reimbursement of individual premiums on an after-tax basis. If so, that door has now been closed, as well.

In three Frequently Asked Questions (“FAQs”) issued on November 6, 2014, the agencies announced that even after-tax premium reimbursements will violate the ACA. According to the FAQs, an employee must have “an unfettered right to receive the employer contributions in cash.” Absent such a cash option, the subsidy will be treated as an employer premium payment. And that will cause the arrangement to fall outside of the “voluntary insurance arrangement” exemption from ERISA’s definition of a “welfare plan” — making it an employer payment plan. In essence, only a true, after-tax payroll deduction option will avoid an ACA violation.

The FAQs also address a related situation. Some employers are apparently offering high-risk employees a cash incentive to waive their right to coverage under the employer’s health plan. In addition to the ACA violation noted above, the agencies have concluded that such an incentive violates the HIPAA prohibition on discriminating against individuals on the basis of their health status. Basically, they view the cash incentive as an increase in the amount of the premium such an employee must pay to gain coverage under the employer’s plan. Such a higher premium (if charged only to employees who are likely to incur higher claims) constitutes impermissible health-status discrimination under HIPAA.

Yet another of the FAQs addresses “Section 105 reimbursement plans.” According to the agencies, these plans are created when an employer cancels its group insurance policy, retains an insurance agent or broker to help its employees select individual insurance policies on a public Exchange, and then reimburses those employees for a portion of the premiums they must pay for that coverage. Some of the employees even receive a federal tax subsidy
to help pay those premiums, as well.

Not surprisingly, the agencies frown on such an arrangement. They view it as an employer payment plan, falling outside of the ERISA exemption for “voluntary insurance arrangements” because the employer is paying a portion of an employee’s premium. As a consequence, the arrangement is subject to the ACA mandates, many of which it fails to satisfy.

For good measure, the agencies note that any employee who is covered under such an arrangement would be ineligible for a federal premium subsidy. So even that “employee-friendly” aspect of the arrangement turns out to be fictitious.

**State Regulation of Stop-Loss Policies**

The ACA seems to have rekindled a greater interest among employers in establishing self-funded health plans. This is because such plans avoid many – though not all – of the ACA requirements. They also escape state insurance regulation. Even employers with relatively few employees have been moving in the self-funded direction.

To protect themselves against the risk of large claims, however, these smaller employers typically purchase stop-loss coverage with very low specific and/or aggregate attachment points. These policies might reimburse an employer for claims incurred by any one participant in excess of $5,000 per year, or by all plan participants of more than 100% of the expected annual amount. The agencies believe that stop-loss coverage with such low attachment points essentially converts a self-funded plan into a fully insured plan – but without the participant protections afforded by either the ACA or state law.

Viewing such arrangements as abusive, the National Association of Insurance Commissioners (“NAIC”) has adopted a model law prohibiting the sale of stop-loss policies with a specific annual attachment point below $20,000. And for small groups (50 or fewer employees), the aggregate attachment point would have to be at least 120% of the plan’s expected claims. Thus far, ten states have adopted this NAIC approach.

Some employers and third-party administrators have questioned, however, whether states have the right to regulate stop-loss coverage in this way. They argue that ERISA preemption, which shields self-funded plans from state insurance regulation, also extends to any stop-loss policies purchased by those plans.

In Technical Release 2014-01, the Department of Labor has assured state insurance regulators that ERISA does not preempt any state law prohibiting stop-loss insurers from issuing policies with attachment points below specified levels. Presumably, those states that have already enacted minimum attachment points will now feel free to enforce those requirements. Other states may also decide to adopt the NAIC model law. Sponsors of self-funded plans with stop-loss attachment points below those set forth in that model law should track this issue closely.

**Conclusion and Next Steps**

There is no guarantee, of course, that the agencies are done issuing this type of ACA guidance. In fact, more guidance is likely to come. And it’s still possible that, rather than being the Little Dutch Boy, the agencies will find themselves in the position of King Canute – unable to stop the waves of ACA work-abouts.

Nonetheless, employers that have implemented unusual arrangements sold as “ACA-compliant” may want to think again about whether the sales pitch they received sounded too good to be true. If may well have been. In that case, the sooner an employer takes steps to comply with this and future agency guidance, the less likely they are to face substantial penalties for noncompliance with the ACA.