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More Health Reform Guidance from the Feds: Mix of Good and Bad News for Employers

Executive Summary

- Federal authorities have postponed a March 1 deadline for employers to distribute a notice to employees explaining the public health insurance exchanges.
- Recently proposed regulations from the Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) appear to allow *any* employer-based health plan more robust than a dental plan, vision plan or health flexible spending account, to satisfy the health reform law's "individual mandate," opening up legitimate and aggressive planning opportunities for some employers.
- The HHS regulations also outline how the public health insurance exchanges will determine whether a person qualifies for a federal subsidy toward the purchase of individual insurance coverage through an exchange. The issue is important because in many cases such subsidies will trigger presumptive penalties against the person's employer.
- The recently proposed regulations also spell out how an employer may appeal a determination that one of its full-time employees is entitled to subsidies through an exchange. Employers will want to understand the appeal process in order to reverse erroneous penalty assessments under the reforms law's play or pay mandate.
- The IRS has also clarified that an offer of qualifying and affordable employee-only coverage disqualifies the employee's *dependents* from receiving federally-subsidized coverage through a public insurance exchange. This might make it more difficult for employers to eliminate dependent coverage, or to substantially scale back the portion of dependent coverage paid by the employer.
- Other new guidance prohibits employers' use of health reimbursement arrangements (HRAs) to help employees buy individual insurance policies (on a tax-favored basis) through a public health insurance exchange or otherwise, calling into question the viability of some employers' hopes to utilize *private* health insurance exchanges after 2013.

The federal agencies implementing 2010's federal health reform law, the Patient Protection and Affordable Care Act (PPACA), continue to turn the crank on guidance related to implementation of the health reform law, including the interaction of federal subsidies for

health insurance exchange-based coverage and the employer "play or pay" mandate. The new guidance is a mix of formal guidance (proposed and final regulations) and informal guidance, in the form of Frequently Asked Questions (FAQs). While the latest burst of agency activity answers some lingering questions, the results are a mix of good news and news that could cause concern for employers. Being optimists, we'll start with the good news.

Delay for Employer Obligation to Notify Employees about Insurance Exchanges

The health reform law requires that employers provide current and new employees a written notice, not later than March 1, 2013, regarding the existence of the public, state-based health insurance exchanges and the availability there of federal subsidies toward the purchase of individual insurance policies if the employer does not offer qualifying and affordable coverage to its employees.

Noting that the federal agencies are committed to a "smooth implementation process," the Department of Labor (DOL) will not require distribution of the notice by March 1. Instead, the agency will issue guidance later this year that will likely require distribution of the notice to coordinate with the public exchanges' enrollment period that will take place beginning this October.

"Minimum Essential Coverage" Continues to Look Potentially Skinny

The notion of "minimum essential coverage" is an important one under the PPACA. Individuals must have minimum essential coverage, beginning in January 2014, to satisfy the PPACA's individual mandate. If they fail to have such coverage they are subject to a relatively modest tax penalty that the IRS may collect by offsetting any federal income tax refund due the individual. A taxpayer owes the penalty not only himself or herself, but also on any federal tax dependent in the household who does not have minimum essential coverage.

Larger employers, for their part, must offer minimum essential coverage to at least 95 percent of their full-time employees (and the employees' biological, step, adopted and foster children, up to age 26), or risk a nondeductible penalty of up to \$2,000 per year for each full-time employee under the employer's taxpayer identification number. The employer, however, receives a free pass on its first 30 full-time employees, in the penalty calculation.

So precisely how *good* must this minimum essential coverage be? Recently proposed regulations say that Medicaid (with certain exceptions for some limited types of Medicaid-based coverage), Medicare and a host of other government-supplied health insurance (including the Children's Health Insurance Program (CHIP), TRICARE, and most Veterans Administration coverage) amount to "minimum essential coverage." Self-insured student health coverage, and coverage provided in the United States to foreign nationals by their home country, also make the grade. Coverage under state high risk pools does, too.

In addition, it appears *any* employer-based healthcare plan more robust than a dental or vision plan, or health flexible spending account, amounts to "minimum essential coverage." However, on-site clinics are not minimum essential coverage, nor is disability or long-term care insurance, hospital or other fixed indemnity insurance, or coverage for specified diseases or illnesses (e.g., a "cancer policy").

Lockton Comment: The proposed regulations, if finalized without significant

change, are important because some employers have contemplated offering very skinny employer-based medical insurance, at very inexpensive rates, as a means for an employee to satisfy his or her individual mandate. It appears this remains a viable strategy. It may work particularly well when offered alongside a plan that barely satisfies the secondary employer obligation to offer coverage that satisfies minimum actuarial value and affordability requirements.

HHS Outlines Process for Verifying Individuals' Eligibility for Exchange-Based Insurance Subsidies...and How Employers May Appeal Penalty Assessments

The proposed regulations from HHS include voluminous guidance on the process it will use in 2014 and 2015 to determine whether an individual qualifies for a federal subsidy when he or she purchases insurance coverage through a public health insurance exchange. In some cases, when an employee qualifies for subsidies, that determination will trigger penalties against his or her employer. Therefore, HHS has also outlined the process by which employers may appeal an exchange's determination that an employee qualifies for subsidies.

Beginning in 2014, an employer's full-time employees (FTEs) will qualify for federally-subsidized coverage through an exchange *only* if the employee satisfies several conditions. First, the employer must have failed to offer health coverage with a minimum actuarial value of 60 percent (we've called this "qualifying coverage") that is "affordable" to the employee.

Lockton Comment: Federal authorities will shortly issue an actuarial calculator to help plans determine whether they meet the minimum value requirement. Recent guidance gives employers three "safe harbors" for satisfying the affordability requirement.

Second, the employee must not be *enrolled* in employer-based minimum essential coverage (whether or not it's qualifying and affordable). Third, the employee must not be eligible for Medicare, Medicaid or other government-supplied health insurance. Fourth, the employee's household income must not exceed 400 percent of the federal poverty level.

Lockton Comment: Recent guidance from the IRS has confirmed that an offer of qualifying and affordable employee-only coverage disqualifies the employee's family members from receiving federally-subsidized coverage through an exchange. Stated differently, the cost of *family* coverage, no matter how expensive, will not render the dependents eligible for subsidized, exchange-based coverage if the offer of employee-only coverage is considered qualifying and affordable.

This may lead some employers to think twice about notions of offering qualifying and affordable coverage to the employee, but dropping or significantly raising the cost of family coverage, if the notions were based on an assumption that the family members could obtain subsidized, exchange-based coverage.

Also included in the guidance are the proposed mechanics of an appeal process individuals and employers may use to dispute an exchange's determination that a federal subsidy is or is not available to the individual. We won't discuss the appeal process for individuals.

Federal authorities intend to build a massive federal "data hub" that is supposed to pull

together information about an individual's employment, coverage offerings by his or her employer, the individual's tax filings, and his or her coverage--or eligibility for coverage--under programs like Medicare, Medicaid, CHIP, TRICARE, etc. Accurate information about the individual is critical, to allow the exchanges to make accurate decisions regarding the individual's eligibility for subsidized exchange-based coverage, and the amount of those subsidies.

Until this data hub is operational and running smoothly, an exchange's process for determining whether a person gets a subsidy (and hence whether his or her employer is penalized) appears to rely a great deal on assertions by the individual, and thus appears to be fraught with peril for employers.

Verification Process for Individuals

Before an exchange will provide an individual with a federal subsidy for coverage, it is supposed to verify information, including:

- The person's household income,
- Whether or not the person has access to qualifying and affordable employment-based coverage (either as an employee, or spouse or child of an employee), and
- Whether or not the person is eligible for or enrolled in Medicare or Medicaid, etc.

In order to qualify for a subsidy, the person's household income must be below four times the federal poverty level (\$92,200 for a family of four in 2013). The size of the subsidy also depends on household income, which is basically adjusted gross income with some modifications.

The exchange will use tax information obtained from the Social Security Administration and IRS as the starting point for this determination. However, the individual is allowed to simply attest to either increases or decreases in household income, and changes not reflected in other data available to HHS. The exchange is tasked with attempting to resolve any inconsistencies before making a final determination of household income for purposes of the subsidies.

Part two of the equation is whether the person is a full-time employee (or spouse or child of a full-time employee) and has access to qualifying and affordable employer coverage. Here, at least for now, the exchange will simply accept an individual's attestation as to full-time status and the cost and design of the employer coverage. The exchange is supposed to investigate any apparent inconsistencies in the individual's attestation (for example, by contacting his or her employer to verify access to employment-based coverage, and the actuarial value and cost of that coverage). HHS has asked for comments regarding how best to streamline this process, such as a template employers could use to provide information about available coverage.

Appeal Process for Employers

If an employee is determined to qualify for federal subsidies toward the purchase of exchange-based health insurance (because, for example, the employee attests that he or she is not offered qualifying and affordable coverage by his or her employer), the exchange will notify the employer of that fact. Although the exchange won't literally penalize the employer, it appears the exchange's determination will serve as the basis for a subsequent excise tax assessment upon the employer by the IRS. The HHS proposed

rules provide an appeals process for employers whose employees are determined to qualify for federal subsidies.

Within 90 days of the determination, the employer may submit plan design, cost-sharing and other information to dispute the exchange's determination. A government official will determine whether to rescind the employee's subsidy award. If the award is not rescinded, HHS is contemplating a couple of possibilities regarding what happens next. Under one possibility, the official's decision is simply final, and the employer must live with it or pursue challenges--through IRS channels--once the IRS levies the consequent excise tax penalty.

Lockton Comment: This is not a particularly appealing proposition (pun intended) to some employers. Employers who have suffered at the whims of unemployment compensation determinations may justifiably be a bit cynical about the fair shake they can expect in these appeals to the health insurance exchanges.

More Guidance on HRAs

In a series of FAQs, federal agencies addressed how the health reform law's prohibition on annual and lifetime dollar limits applies to health reimbursement arrangements (HRAs). HRAs are problematic under the PPACA's prohibition on dollar limits because by their nature they provide benefits limited to a specific dollar amount. Previously, the agencies indicated that an HRA that is *integrated* with group medical coverage would satisfy the requirement if the group coverage contained no prohibited dollar limits.

What the agencies meant by "integrated" was not entirely clear, but it appeared that an HRA made available to an enrollee in a medical plan, and which could be used to offset out-of-pocket expenses under the plan (e.g., deductibles, co-payments and co-insurance) would be considered "integrated" with the medical plan. "Stand-alone" HRAs, such as HRAs offered to individuals not enrolled in the employer's group medical plan, would be prohibited, at least after 2013.

The new guidance indicates that an employer-sponsored HRA cannot be considered "integrated" with coverage purchased on the individual market or even with individual policies offered through an employer.

Lockton Comment: The agency guidance closes the door on the notion of an employer using an HRA to provide tax-free dollars to an employee for the purchase of individual coverage through a public health insurance exchange, *or even a private exchange*. Consequently, an employer will have to provide its employees with additional taxable cash compensation if it wants to facilitate employees' purchase of individual policies.

The FAQs also preclude the use of a tax-free "opt out" credit in an HRA if an employee waives medical coverage through its employer. Presumably, at least for now, an employer may continue to supply additional taxable cash to employees who opt-out of the employer's group coverage.

The FAQs permit residual balances (as of January 1, 2014) in non-integrated HRAs to be used until the funds are exhausted, with certain limitations to prevent employers from abusing this accommodation.

Lockton Comment: Note that these prohibitions on HRAs do not apply to HRAs that cover only retirees.

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