

July 2, 2013

Feds Offer Short Reprieve from Individual Mandate, Finalize Rules on “Minimum Essential Coverage” and Contraception Benefits

Federal authorities implementing the health reform law issued several pieces of guidance late last week, excusing the individual mandate for part of 2014 for individuals offered coverage under non-calendar year employer plans, and finalizing rules regarding “minimum essential coverage” and the controversial contraception benefit mandate.

Reprieve from Individual Mandate

Under the reform law, individuals are required to have at least modest health insurance coverage (minimum essential coverage) by January 1, 2014, or could incur penalties that will be calculated on their federal income tax returns.

This creates a vexing problem for individuals eligible for but not enrolled under coverage through an employer-based plan where the plan year doesn’t commence January 1. For example, what if the plan year commences July 1? Must the individual enroll effective July 1, 2013 — even if he or she does not want the coverage prior to 2014 — in order to be sure coverage is in effect on January 1, 2014?

The Internal Revenue Service (IRS) says “no.” If an individual is offered at least minimum essential coverage under a non-calendar year employer health plan whose plan year begins in 2013 and ends in 2014, the individual is excused from the individual mandate through the last day of the 2013-14 plan year.

Lockton Comment: “Minimum essential coverage,” or MEC, means, with respect to coverage offered by an employer, any insured or self-insured coverage more robust than an “excepted benefit,” such as most dental or vision plans and most health flexible spending accounts. Thus, it is a rather low bar. For purposes of the employer “play or pay” mandate, large employers must offer MEC to at least 95 percent of their full-time employees and their children, or pay a \$166.67 nondeductible penalty per month (\$2,000 per year) for each full-time employee, after disregarding the first 30 full-time employees.

Significantly, this grace period applies even if the individual is *also* offered coverage under *another* plan (e.g., perhaps sponsored by a spouse’s employer) that operates on a calendar year basis.

Lockton Comment: This is a nice accommodation because it does not force the individual to enroll in the other coverage simply because it's offered under a calendar year plan.

Federal authorities offer two examples:

Example 1: Bonnie is unmarried and has a five-year-old daughter, Debra. Bonnie is eligible to enroll herself and Debra in a non-calendar year health plan offered by Bonnie's employer. The 2013-14 plan year begins on August 1, 2013, and ends on July 31, 2014. Neither Bonnie nor Debra enrolls under the plan for the 2013-2014 plan year. Bonnie and Debra are excused from the individual mandate from January 1, 2014, through July 31, 2014.

Example 2: Frank and Gloria are married. They are both eligible to enroll in a non-calendar year health plan offered by Frank's employer (the 2013-14 plan year begins on August 1, 2013, and ends on July 31, 2014). In addition, both are eligible to enroll in a calendar year plan offered by Gloria's employer, which has a plan year beginning January 1, 2014. Neither Frank nor Gloria enrolls in either plan. Nevertheless, both are excused from the individual mandate through July 2014.

This reprieve from the individual mandate dovetails with similar relief previously given to *employers*. Under proposed regulations issued late last year, federal authorities excused some employers with non-calendar year plans from the "play or pay" mandate until the first day of their 2014-15 plan year. The proposed regulations also permit employers with non-calendar year plans, if they choose to do so, to allow employees to jump into or out of coverage on January 1, 2014, notwithstanding restrictions (under cafeteria plan "change in status" rules) that would otherwise prohibit such coverage changes. The cafeteria plan accommodation is discussed [here](#).

Speaking of Minimum Essential Coverage...

The notion of MEC is important for both the individual mandate and the employer "play or pay" mandate. Individuals might be fined if they do not have MEC, and large employers might be fined if they do not offer it to at least 95 percent of their full-time employees and their children.

Under the health reform statute, MEC includes any employer-based coverage more robust than an "excepted benefit." However, for employer-provided MEC to disqualify an individual from the possibility of exchange-based subsidies, either (a) the individual must actually be enrolled in the coverage, or (b) the coverage must satisfy "minimum value" (at least 60 percent actuarial value) and "affordability" standards.

There has been some question or concern about whether federal authorities would consider bare-bones employer coverage (e.g., "preventive care-only" coverage) to be MEC. Doing so would allow an individual enrolled in the skimpy coverage to satisfy the individual mandate, and his or her employer to satisfy the MEC component of the play or pay mandate. Last week's guidance package includes final regulations addressing MEC, for purposes of the individual mandate. Federal authorities imposed no additional requirements on employer-supplied MEC. Thus, it appears that bare-bones coverage will indeed constitute MEC, opening up additional planning opportunities for some employers.

From the individual's perspective, MEC also includes Medicaid, Medicare, the Children's Health Insurance Program (CHIP), TRICARE and (at least for 2014) self-insured student health plans and state high risk pools. This is important because an individual eligible for MEC via a government program is *ineligible* for federal subsidies toward the cost of an individual health insurance policy sold through a public health insurance exchange.

In last week's guidance, the IRS concluded that if an individual is:

- Ineligible for coverage under Medicaid or CHIP for a "lockout period," due to failure to pay a premium, he or she is nevertheless considered eligible for MEC and is thus *ineligible* for federal subsidies in a public health insurance exchange.
- Eligible for CHIP but not covered due to a pre-enrollment waiting period, the individual is treated as *ineligible* for CHIP, and thus could be eligible for exchange-based subsidies.
- Seeking coverage under Medicare or Medicaid on account of disability or illness, but the relevant agency has not yet made the eligibility determination, the individual is not considered eligible for Medicare and Medicaid and thus could be eligible for exchange-based subsidies.

If the individual is eligible for MEC under any of the following coverages, *but is not actually enrolled*, he or she could be eligible for exchange-based subsidies:

- Medicare Part A coverage requiring the payment of premiums.
- A state high risk pool.
- A self-funded student health plan designated as MEC by the Department of Health and Human Services, or the Reserve Select, Retired Reserve, Young Adult or Continued Health Care Benefit Program under TRICARE.

Final Rules on Contraception Coverage

The Affordable Care Act (ACA) requires non-grandfathered health plans to supply a wide variety of preventive care services at no out-of-pocket cost to enrollees. Included in these services is a well-woman care benefit that requires cost-free provision of any FDA-approved contraceptive device.

This rule inflamed the passions of many religious organizations, quasi-religious organizations and even private companies owned by individuals whose religious beliefs conflict with the notion of contraception. In response, the Administration quickly exempted churches and tried to pacify quasi-religious organizations (religious-affiliated hospitals and schools, for example) by deferring the effective date of the mandate, but pretty much expected for-profit companies to comply.

Several such companies promptly sued the Administration, alleging, among other things, infringement on the religious freedoms of the companies' owners. Just a few days ago a federal appeals court allowed such a suit, filed by Hobby Lobby, to proceed.

With respect to the quasi-religious organizations, however, the Administration tried to pacify both sides in the debate, and has come up with a solution that is, to put it kindly, extraordinarily complicated.

In final regulations issued last week, the Administration offers wiggle room to “eligible organizations” (EOs). These are nonprofit organizations (generally, other than churches, associations or conventions of churches, or religious orders, which are already exempt from the mandate) that hold themselves out as religious organizations, and oppose providing contraception benefits under a health plan on religious grounds.

If an EO certifies to its insurer or its third-party administrator (TPA) that it is an EO, then the insurer or TPA must find a way to provide the contraception benefit directly to female enrollees for as long as they are covered by the plan. The insurer or TPA cannot pass along to the EO, directly or indirectly, the cost of providing the contraception benefit. Insurers must literally segregate premium revenue collected from EOs from the monies used to pay for contraceptives supplied to the plan’s female enrollees.

If insurers and TPAs can’t ask the certifying EO to pay for contraception benefits, and can’t even spread the cost of doing so over their entire books of business, how are they to pay for the benefit? The final regulations provide that if the plan is insured, and the insurer is paying user fees to a federally-facilitated public health insurance exchange (for the privilege of offering its products in the exchange), it may claim an offset against the user fees in an amount equal to the cost of providing the contraception benefits, plus a small markup to cover administrative costs.

But what about the TPAs? They don’t play in the public health insurance exchanges. The final regulations say they can find an insurer that *does* play in the exchanges, and ask it to submit a request for an offset of exchange user fees on behalf of the TPA. When the insurer receives the offset, it must promptly forward the money to the TPA. Both insurers and TPAs must keep records of these transactions for 10 years.

Insurers and TPAs have an annual notice obligation with respect to participants and dependents covered under a plan sponsored by a customer who is a certifying EO. The notice lets the plan’s members know that the sponsor does not fund contraception benefits, but the insurer or TPA will pay for them.

For certifying EOs whose plans are self insured and subject to ERISA, the TPA literally becomes the ERISA “plan administrator” with respect to contraception benefits, and picks up the obligation to establish and operate procedures for processing claims for contraception benefits, and “complying with disclosure and other requirements applicable to group health plans under...ERISA with respect to such benefits.” Presumably, the TPA will have some kind of obligation to provide an SPD-like summary of contraception benefits, and provide other disclosures and reports.

*Edward Fensholt, J.D.
Compliance Services Division*

Not Legal Advice: Nothing in this Alert should be construed as legal advice. Lockton may not be considered your legal counsel and communications with Lockton's Compliance Services group are not privileged under the attorney-client privilege.

Circular 230 Disclosure: To comply with regulations issued by the IRS concerning the provision of written advice regarding issues that concern or relate to federal tax liability, we are required to provide to you the following disclosure: Unless otherwise expressly reflected herein, any advice contained in this document (or any attachment to this document) that concerns federal tax issues is not written, offered or intended to be used, and cannot be used, by anyone for the purpose of avoiding federal tax penalties that may be imposed by the IRS.