ACA Countdown to Compliance

52 Week Series For Employers

In this volume, we have collected the 52 weekly blog posts that comprise the series entitled, The Affordable Care Act—Countdown to Compliance for Employers. The series appeared in the Mintz Levin Employment Matters Blog during 2014. Each of the posts addressed compliance issues affecting employers with a particular, though not exclusive focus on that law's employer shared responsibility (a/k/a "pay-or-play") rules. The end of the series coincided with the January 1, 2015 "go live" effective date of the new rules. The issues discussed week-to-week were generally gleaned from newly issued guidance or developing problems, questions or concerns. While not true in every case, many of the issues that we addressed remain of interest to employers and their advisors. As a consequence, we have assembled the entire series of posts into this single volume, which we hope you find useful.

MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

EMPLOYMENT MATTERS
A blog about current developments and issues in employment, labor and benefits law
MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

Table of Contents

EMPLOYMENT MATTERS
A blog about current developments and issues in employment, labor and benefits law
MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

The Affordable Care Act—Countdown to Compliance for Employers, Week 0: Final Thoughts and Acknowledgements

Posted By Michael Arnold on December 29th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Affordable Care Act is the single most important piece of Federal social legislation in more than a generation. While there was and is broad agreement on the law's principal goals—to expand medical coverage, increase the quality of medical outcomes, and constrain costs—there is little agreement on the "means whereby." This is perhaps both unavoidable and unfortunate. Unavoidable given the partisan political environment from which the ACA sprang and in which it now lives; unfortunate because, at bottom, there are few viable alternatives. If Congress was considering health care finance for the first time, as if on a blank slate, no one thinks that they would design anything remotely like our current fragmented system. But Congress did not and does not have that luxury.

Despite the preference of some on the political left, we do not as a country have the collective political will to adopt a single-payer system. Despite the preference of some on the political right, we do not as a country have the collective political will to permit but not require all U.S. citizens to purchase individual coverage, subsidized perhaps with tax credits for certain low- and moderate-income individuals, across state lines. (There are, to be sure, gradations on this rather admittedly crude model of the political spectrum, but in the author's view they don't much change the analysis.) What remains is the middle road, which calls for the reform of existing market and regulatory structures: employer-based group health insurance, coverage provided by commercial carriers in the individual and group markets, and government programs for low-income individuals, children, and the aged. The ACA works within rather than disrupting existing market-based legal and regulatory structures. It reforms but does not displace the private health insurance markets; relies on but does not displace employer-sponsored group health coverage; and expands but does not displace Medicare, Medicaid and other existing government programs.

In 2006, the Commonwealth of Massachusetts overhauled its health care financing rules by adopting a market- and regulatory-based approach that included five key components: an individual mandate, an employer mandate, low-income subsidies, a public insurance exchange, and associated tax reforms to pay for it all. The design was due in large part to the work of the right-leaning Heritage Foundation, and the law was the joint effort of a Republican Governor (Mitt Romney) and a decidedly left-leaning democratic legislature. The Massachusetts law served as the blueprint for the ACA, which includes the same five components. That the two laws share the same chassis should surprise no one. In each case the policymakers faced the daunting constraints of a larger political, social, and cultural environment, and they reacted accordingly.

Contrary to the claims of some of the law's detractors, the ACA is not a "government takeover" of health care. That happened about 50 years ago, in July of 1965 to be exact, with the enactment of Medicare. But it is accurate to say that the ACA federalized the regulation of health care by establishing a comprehensive Federal regulatory superstructure that replaced the piecemeal approach of prior law. This is particularly true in the case of the regulation of individual and group health insurance, which was (since 1945) under the primary jurisdiction of the states.

The ACA sits atop a major tectonic plate of the U.S. economy, nearly 18% of which is health care related. Health care providers, commercial insurance carriers, and the vast Medicare/Medicaid complex are the law's primary stakeholders. They, and their local communities, have much to lose or gain depending on how health care financing is regulated. The ACA is the way it is largely because of them. Far more than any other circumstance, including which political party controls which branch of government, it is the interests of the ACA's major stakeholders that determine the law's future. And there is no indication whatsoever that, from the perspective of these entities, the calculus that drove the ACA's enactment has

changed. U.S. employers, even the largest employers among them, are bit players in this drama. They have little leverage, so they are relegated to complying and grumbling (not necessarily in that order).

The requirements imposed on employers by the ACA are in many cases complex and difficult. Myriad technical corrections are needed, and there is no shortage of good (and bad) ideas for amendments. Sometimes overlooked, however, is that the regulators (principally, the Departments of Health and Human Services, Labor, and Treasury/IRS) have already done much to make the ACA rules that apply to employers workable—even if they don't always feel that way. In addition, certain industry, trade, and professional organizations have done yeomen's work both in providing comments and informing and educating their members. The same can be said of more than a handful of law-firms, benefit consultants, and accounting and actuarial firms, among others. Recognizing that any such list will be woefully incomplete, I offer the following acknowledgements:

- As a member of the Employee Benefits Committee of the American Bar Association, I have had the opportunity to meet personally some of the government representatives with front-line responsibilities for ACA implementation. These folks generally shun the spotlight, (rightly) preferring instead to let their respective agencies' formal guidance speak for them. So I will not single any of them out. But I will say that these folks are to a person smart, gracious and fair. Occasionally, they come under criticism from members and others. When that happens, it usually stems from a failure to recognize that the regulators are tasked with carrying out the will of our elected representatives.
- As co-chair of the Welfare Plan Issues, EEOC, FMLA, and Leave Issues Subcommittee of the ABA Tax Section's Employee Benefits Committee, **Linda Mendel** (Vorys, Sater, Seymour and Pease LLP) has led the committee's efforts to educate members on the ACA. In that effort, she early on enlisted **Helen Morrison** (formerly of the Treasury Department's Office of Tax Benefit Counsel and currently Ernst & Young, LLP). Both women, and those that they have recruited to their cause, are tenacious in their collective efforts to understand the law and communicate it in a way that folks get it.
- When it comes to commentators on the ACA, Professor **Tim Jost** at Health Affairs Blog is in a class by himself. His commentary, which is far broader than just employer issues, is prolific and insightful. Similarly remarkable in usefulness and scope is the commentary provided by the **Kaiser Family Foundation** and the **Urban Institute**.
- The **ERISA Industry Committee** (ERIC) and the **American Benefits Council** deserve special attention. **Gretchen Young**, ERIC's Senior Vice President for Health Policy, has labored tirelessly and with her signature sense of humor to keep ERIC members up-to-date and to advance her members' interests. (Disclosure: Mintz Levin is an ERIC member.) The same can be said for **Kathryn Wilber**, Senior Counsel, Health Policy, of the American Benefits Council, and for her outside counsel, **Seth Perretta** of the Groom Law Group.
- Law, accounting, actuarial, and consulting firms have put out a steady stream of informative commentary, much directed squarely at employers and their advisors. Earlier drafts of this blog sought to list them, but it became apparent with each successive effort that this was a fool's errand. So many folks did such good work that any such list would serve only to polarize and annoy.
- Some final notes of thanks: To **Ed Lenz**, Senior Counsel of the American Staffing Association (and a Senior Advisor to Mintz Levin), my friend and co-author on many of the year's blog posts; to my colleagues (lawyers and non-lawyers alike) at Mintz Levin who are a delight to work with, even on the bad days; to the readers of this blog (I hear from some of you from time-to-time, so I know that *someone* is reading it); and, last and most importantly, to the firm's clients that I have the privilege of serving. Without them, I would be unable to do this work.

Tags: ACA, Affordable Care Act, American Benefits Council, American Staffing Association, Department of Labor, Departments of Health and Human Services, Employee Benefits Committee of the American Bar Association, ERISA Industry Committee, Heritage Foundation, IRS, Massachusetts, Medicare, Mitt Romney

The Affordable Care Act—Countdown to Compliance for Employers, Week 1: Going Live with the Affordable Care Act's Employer Shared Responsibility Rules on January 1, 2015 . . . What Can Possibly Go Wrong?

Posted By Michael Arnold on December 22nd, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Regulations implementing the Affordable Care Act's (ACA) employer shared responsibility rules including the substantive "pay-or-play" rules and the accompanying reporting rules were adopted in February. Regulations implementing the reporting rules in newly added Internal Revenue Code Sections 6055 and 6056 came along in March. And draft reporting forms (IRS Forms 1094-B, 1094-C, 1095-B and 1095-C) and accompanying instructions followed in August.

With these regulations and forms, and a handful of other, related guidance items (e.g., a final rule governing waiting periods), the government has assembled a basic—but by no means complete—compliance infrastructure for employer shared responsibility. But challenges nevertheless remain. Set out below is a partial list of items that are unresolved, would benefit from additional guidance, or simply invite trouble.

1. Variable Hour Status

The ability to determine an employee's status as full-time is a key regulatory innovation. It represents a frank recognition that the statute's month-by-month determination of full-time employee status does not work well in instances where an employee's work schedule is by its nature erratic or unpredictable. We examined issues relating to variable hour status in previous posts dated April 14, July 20, and August 10.

An employee is a "variable hour employee" if—

Based on the facts and circumstances at the employee's start date, the employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain.

The final regulations prescribe a series of factors to be applied in making this call. But employers are having a good deal of difficulty applying these factors, particularly to short-tenure, high turnover positions. While there are no safe, general rules that can be applied in these cases, it is pretty easy to identify what will not work: classification based on employee-type (as opposed to position) does not satisfy the rule. Thus, it is unlikely that a restaurant that classifies all of its hourly employees, or a staffing firm that classifies all of its contract and temporary workers, as variable hour without any further analysis would be deemed to comply. But if a business applies the factors to, and applies the factors by, positions, it stands a far greater chance of getting it right.

2. Common Law Employees

We addressed this issue in our post of September 3, and since then, the confusion seems to have gotten worse. Clients of staffing firms have generally sought to take advantage of a special rule governing offers of group health plan coverage by unrelated employers without first analyzing whether the rule is required.

While staffing firms and clients have generally been able to reach accommodation on contractual language, there have been a series of instances where clients have sought to hire only contract and temporary workers who decline coverage in an effort to contain costs. One suspects that, should this gel into a trend, it will take the plaintiff's class action bar little time to respond, most likely attempting to base their claims in ERISA.

3. Penalties for "legacy" HRA and health FSA violations

A handful of promoters have, since the ACA's enactment, offered arrangements under which employers simply provided lump sum amounts to employees for the purpose of enabling the purchase of individual market coverage. These schemes ranged from the odd to the truly bizarre. (For example, one variant claimed that the employer could offer pre-tax amounts to employees to enroll in subsidized public exchange coverage.) In a 2013 notice, the IRS made clear that these arrangements, which it referred to as "employer payment plans," ran afoul of certain ACA insurance market requirements. (The issues and penalties are explained in our June 2 post.) Despite what seemed to us as a clear, unambiguous message, many of these schemes continued into 2014.

Employers that offered non-compliant employer-payment arrangements in 2014 are subject to penalties, which must be self-reported. For an explanation of how penalties might be abated, see our post of April 21.

4. Mergers & Acquisitions

While the final employer shared responsibility regulations are comprehensive, they fail to address mergers, acquisitions, and other corporate transactions. There are some questions, such as the determination of an employer's status as an applicable large employer, that don't require separate rules. Here, one simply looks at the previous calendar year. But there are other questions, the answers to which are more difficult to discern. For example, in an asset deal where both the buyer and seller elect the look-back measurement method, are employees hired by the buyer "new" employees or must their prior service be tacked? The IRS invited comments on the issue in its Notice 2014-49 (discussed in our post of September 29).

Taking a page from the COBRA rules, the IRS could require employers to treat sales of substantial assets in a manner similar to stock sales, in which case buyers would need to carry over or reconstruct prior service. While such a result might be defensible, it would also impose costly administrative burdens. Currently, this question is being handled deal-by-deal, with the "answers" varying in direct proportion to the buyer's appetite for risk.

5. Reporting

That the ACA employer reporting rules are in place, and that the final forms and instructions are imminent should give employers little comfort. These rules are ghastly in their complexity. They require the collection, processing and integration of data from multiple sources—payroll, benefits admiration, and H.R., among others. What is needed are expert systems to track compliance with the ACA employer shared responsibility rules, populate and deliver employee reports, and ensure proper and timely delivery of employee notices and compliance with the employer's transmittal obligations. These systems are under development from three principal sources: commercial payroll providers, national and regional consulting firms, and venture-based and other start-ups that see a business opportunity. Despite the credentials of the product sponsors, however—many of which are truly impressive—it is not yet clear in the absence of actual experience that any of their products will work. It is not too early for employers to contact their vendors and seek assurances about product delivery, reliability, and performance.

Tags: ACA, Affordable Care Act, COBRA, employer shared responsibility rules, ERISA, FSA, HRA, initial measurement period, IRC Section 6055, IRC Section 6056, IRS, pay-or-play rules, variable hour employee

The Affordable Care Act—Countdown to Compliance for Employers, Week 2: Explaining the Look-Back Measurement Method to Employees

Posted By Michael Arnold on December 16th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, DOL, IRS

Written By Alden J. Bianchi and Edward A. Lenz

Many applicable large employers—i.e., employers that are subject to the Affordable Care Act's (ACA) employer shared responsibility rules—have a pretty good sense of what these rules are, how they work, and what they plan to do to comply. A subset of these employers has gained a sophisticated understanding of the employer shared responsibility rules, while another (hopefully much smaller) subset has only a vague sense that they need to do *something* by or in 2015 in connection with extending coverage to full-time employees.

Employers with large groups of employees who were previously not offered coverage, or those with large variable and contingent workforces, have generally been relieved to learn that, in the case of employees with unpredictable hours, they may be able to determine the employee's status as full-time using the "look-back measurement method." (For a description of the look-back measurement method, please see the IRS' "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act," Question 15). Even after having the particulars of the look-back measurement method explained to them more than once, the H.R. and finance professionals with front-line responsibility for compliance sometimes confess confusion about how these rules work. And even among those with a firm grasp of the particulars, there remains a lingering worry. Once management and H.R. have a grasp of the rules and have settled on a compliance strategy, they must next figure out how to explain the rules to employees in a way that complies with applicable law and actually works for employees (the two are not necessarily the same).

- ***The ERISA Disclosure Rules***

At bottom, the look-back measurement method for determining an employee's full-time status affects whether and when an employee must be offered group health plan coverage. It is, therefore, something that must be communicated to employees. How this communication is accomplished is dictated by another Federal law, the Employee Retirement Income Security Act of 1974 (ERISA). For group health plans that are subject to ERISA (i.e., all but governmental and church plans), this is the job of a "summary plan description" or "SPD." ERISA generally requires that the terms of an employee benefit plan (which includes group health plans) be set out in a written plan document, and that the material terms of the plan be communicated to participants in an SPD in terms understandable to the average plan participant. Where there is an existing SPD, an amendment explaining the look-back measurement method and other ACA requirements can be added in a "Summary of Material Modifications" or "SMM."

Before the ACA, compliance with the ERISA SPD/SMM requirements was less than robust. Some employers relied on the glossy brochures issued by their insurance carrier to communicate the plan's terms, and the eligibility terms were set out on a page somewhere in the middle of an employee handbook. For any number of reasons (the look-back measurement method included), the ACA has put added pressure on having a compliant SPD. In the case of disputes over the right to benefits, courts routinely look to SPDs. A failure to have an SPD, or having an out-of-date SPD, can place the plan sponsor at a disadvantage. And now that the ACA has added new benefit requirements, there is a good deal more to argue about. There is also the prospect of daily penalties where a plan administrator fails to deliver an SPD once requested by a participant or beneficiary.

Particularly in the case of group health plans, the plan document and SPD are often combined into a single document referred to colloquially as a "wrap" plan document. While not all practitioners agree that wrap plan documents are a good

idea, they appear to have gained wide acceptance. (In our view, the advantages of a wrap document far outweigh any possible disadvantages.)

Generally, an SPD must be provided within 120 days after a plan becomes subject to ERISA, and an SMM or an updated SPD must be issued not later than 210 days after the end of the plan year in which the material change was adopted. Where there has been a material reduction in covered services or benefits, however, the SMM or updated SPD must be issued within 60 days of the adoption of that material reduction. These are minimum requirements, and there are many cases in which earlier, or even advance, notice is required. For example, in the case of a mid-year plan amendment that must be disclosed in a "summary of benefits and coverage" or "SBC," the employer must notify participants at least 60 days prior to the effective date of the amendment. In addition, compliance with the ERISA fiduciary standards may dictate in favor of earlier or even advance notice.

- ***Informal, Supplemental Notices***

Where an employer wants to get out ahead of the formal ERISA disclosure rules, or where an understanding of ERISA's disclosure requirements is in short supply, some employers have sought to explain the look-back measurement method in a separate memorandum or other informal communication to employees. Not a bad idea in our view. Nothing prevents an employer from supplementing the formal ERISA disclosure requirements, and better and more complete communication benefits both the employer and the employee. Set out below is a sample of what such a communication might look like:

The Affordable Care Act (ACA) imposes new rules governing offers of group health plan coverage by employers to their full-time employees. For this purpose, we have chosen to determine which employees are full-time employees under the "look-back measurement method." These rules are explained at some length in our plan's summary plan description (SPD), which is available at [describe]. The purpose of this memorandum is to describe how the look-back measurement method applies to both newly hired and other (ongoing) employees. These rule are important, since they determine the circumstances under which employees qualify for coverage and when.

Upon hire an employee will be classified as full-time, part-time, variable hour, or seasonal.

- *A "full-time employee" is an employee who is expected to work on average 30 or more hours per week during each calendar month.*
- *A "part-time employee" is an employee who is not expected to work on average 30 or more hours per week during each calendar month.*
- *A "seasonal employee" is an employee who is hired into a position for which the customary annual employment is six months or less.*
- *A "variable hour employee" is an employee who we cannot determine is reasonably expected to be employed on average at least 30 hours of service per week during his or her "initial measurement period" (i.e., the 12-month period commencing the first day of the month following date-of-hire) because the employee's hours are variable or otherwise uncertain.*

Employees classified as full-time will be eligible to participate in our plan on the first day of the calendar month immediately following three full months of employment (but only if they are still employed on that day). Part-time, seasonal and variable hour employees must first complete a 12-month initial measurement period (that starts on the first day of the month following date of hire) during which they are not eligible to participate in the plan. At the completion of the initial measurement period, an employee who has worked on average at least 30 hours of service per week during that period will be eligible for coverage on the first day of the next month (i.e., 13-and-a-fraction months after his or her hire date). Employees who qualify for coverage under this rule will remain eligible for a 12-month period (called the "stability period") irrespective of their hours, provided they remain employed. An employee who fails to work on average at least 30 hours per week during his or her initial measurement period is not eligible for coverage during the corresponding stability period.

Employees who have been employed for some time are subject to similar rules, except that the testing period is a fixed, 12-month period that runs from November 1 to the following October 30. This period is called the "standard measurement period." Once an employee has worked through a full standard measurement period, he or she is no longer classified as full-time, part-time, seasonal, or variable hour. He or she is instead an "ongoing employee." An ongoing employee who works on average at least 30 hours of service per week during any standard measurement period will qualify for coverage during a stability period, which is the immediately following calendar year. An ongoing employee who fails to work on average at least 30 hours per week during any standard measurement period is not eligible for coverage during the corresponding stability period.

There are rules that govern the transition from newly-hired to ongoing employee that will affect when coverage might be available. In addition, where an employee experiences a break-in-service of at least 13-weeks, he or she may be treated as newly-hired upon their return. A similar result occurs under a "rule of parity" where a rehired employee may be treated as a new employee following a break of at least four weeks if the employee's break in service is longer than the employee's period of service immediately preceding the break in service.

If you have question about how these rules affect you, please call or contact [insert contact information].

> **NOTE:** This notice makes some assumptions about the employer's choice of measurement periods. Other options are available, of course. Many employers have selected an 11-month initial measurement period, for example. This allows for a two-month administrative period during which an employee may be enrolled in the plan. Also, there is no requirement that the standard measurement period begin November 1, but the period between the end of the standard measurement period and the commencement of the corresponding stability period must not exceed three months.

- ***Delivery—Electronic and Otherwise***

While employers that elect to use the look-back measurement method are required by ERISA to explain how these rules impact employees and their beneficiaries in the SPD (summaries of benefits and coverage do not include eligibility), the notice above is merely supplemental. As a result, there are no restrictions or requirements on how the employer delivers the memorandum. An e-mail would do just fine. SPDs are a different matter. In general, an SPD must be provided in a manner that is "reasonably calculated to ensure actual receipt of the material."

The Department of Labor has provided a safe harbor covering the electronic delivery of SPDs and other documents and information required by ERISA. But this safe harbor requires advance consent in instances where access to the employer's electronic information system is not an integral part of the employee's duties. The Department's safe harbor rules were adopted in 2002. Much has changed since then, and electronic communications have become the norm. As a consequence, many employers have turned to e-mail notice as the default, without worrying about whether they qualify for safe harbor treatment. Employers that choose this approach should be aware that it is not without some risk.

Check back next week for the final installment of *The Affordable Care Act—Countdown to Compliance for Employers.*

Tags: ACA, Affordable Care Act, DOL, ERISA, IRS, look-back measurement method, SBC, SMM, SPD, Summary of Benefits and Coverage, Summary of Material Modifications, summary plan description

The Affordable Care Act—Countdown to Compliance for Employers, Week 3: Group Health Plan, Cafeteria Plan and Health FSA Nondiscrimination Theory and Practice

Posted By Michael Arnold on December 8th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

As applicable large employers grapple with the Affordable Care Act's (ACA) employer shared responsibility (pay-or-play) rules, two questions arise with notable frequency:

- Do I have to offer the same group health insurance coverage on the same terms to all my full-time employees?
- Do I have to offer pre-tax treatment of premiums to all my employees?

These questions—which arise under Internal Revenue Code §§ 105(h) and 125, and Public Health Service Act § 2716—are important as employers endeavor to navigate the penalty provisions of Code § 4980H. They are particularly relevant in the case of employers that previously did not offer coverage to a large group of employees (e.g., in industries such as staffing, restaurants, retail, hospitality and franchising, among others). As we explain below, what makes these questions challenging is that theory varies widely from practice for various reasons. The present issues are ripe for regulatory attention, and it is entirely likely that today's answers will not be tomorrow's answers.

Fully-insured Group Health Plans

Other than a brief period two decades ago, before the ACA there were no non-discrimination standards that applied to fully-insured group health plans. The ACA changed that in newly added Public Health Service Act § 2716, the provisions of which are incorporated into the Internal Revenue Code and ERISA. Enforcement of these new group health plan non-discrimination rules has been delayed indefinitely, however, by IRS Notice 2011-1. So, where the question involves a fully-insured group health plan, the answer is simple: *at least for now*, an employer is currently free to offer different group health insurance coverage to different groups or cohorts of full-time employees with impunity. This will change, of course, once the regulators get around to issuing regulations.

In 1978, when Congress first turned its attention to group health plan non-discrimination, it was of the (subsequently discredited) view that carrier underwriting rules would be sufficient to curb discriminatory plan designs in the case of fully-insured arrangements. Congress had a change of heart, and in the Tax Reform Act of 1986 added the now infamous "Code § 89," which established a mind-numbingly complex set of nondiscrimination rules that applied to a broad range of welfare and fringe benefit plans, including employer-provided group health plans. Proposed regulations issued in 1989 were the subject of intense criticism. Despite some delays in the effective dates, and in spite of an earnest attempt at simplification, intense lobbying pressure (particularly by small business interests) ultimately doomed the measure. Code § 89 was repealed in 1992 (retroactive to 1989). In the process of writing rules under the ACA, the regulators are no doubt mindful of the frosty reception given the 1989 proposed rules.

For a comprehensive discussion of the issues that confront the regulators as they craft non-discrimination rules under Public Health Service Act § 2716, please see the August 3, 2012 comment letter submitted by the American Bar Association Tax Section and a separate outline on the subject prepared by Helen Morrison, Ernst & Young LLP and Linda Mendel, Vorys, Sater, Seymour and Pease LLP.

Self-funded Group Health Plans

Self-funded group health plans are a different matter. Since 1978, Code § 105(h) has imposed rules governing discrimination on the basis of eligibility or benefits. Failure to follow these rules results in the taxation of "excess benefits" in the hands of highly compensated participants. (For a summary of the Code § 105(h) non-discrimination rules, click here.) But an understanding of these rules, no matter how thorough, comprehensive, or accurate, obscures the practical reality: the rules are rarely followed or enforced. And where employers do attempt to follow them, the compliance testing methods adopted by one employer are unrecognizable to another employer following the same rules! This too is likely to change once the regulators turn their attention to group health plan non-discrimination issues generally.

Cafeteria Plans

Cafeteria plan non-discrimination poses an even more daunting problem for two reasons: first, there is not one but up to four non-discrimination tests that apply; and second, there are no final regulations telling us how these rules work. In 2007, the Treasury Department and the IRS issued a comprehensive set of proposed cafeteria plan rules, with particularly detailed non-discrimination provisions. These proposed non-discrimination rules are quite strict. Different levels of employer contributions to the same plan, for example, could trigger a violation. Because the proposed rules are all the guidance we have on the subject, some practitioners treat them as authoritative. They are not. Different levels of employer contributions, for example, are commonplace. This does not mean that there are no rules, however. The statute itself is clear that cafeteria plans may not freely discriminate. A cafeteria plan covering only, say, a (highly paid) headquarters group, will be discriminatory based on *any* reasonable reading of the statute. Beyond that there is little agreement as to where one might draw the proverbial line.

But for the ACA, the proposed 2007 cafeteria plan rules would likely be in final form by now. The regulators will complete this project at some point. When that happens, compliance with the non-discrimination rules will take on a new urgency.

Tags: ACA, Affordable Care Act, Cafeteria Plans, Code § 4980H, excess benefits, Fully-insured Group Health Plans, Internal Revenue Code, IRC, Public Health Service Act, Self-Funded Group Health Plans, Tax Reform Act

The Affordable Care Act—Countdown to Compliance for Employers, Week 4: EEOC v. Honeywell and the Future of Wellness Programs

Posted By Michael Arnold on December 1st, 2014 | Posted in ACA Compliance Series, ADA, Affordable Care Act, EEOC

Written by Alden J. Bianchi

While my entries have focused principally on the employer shared responsibility rules of the Affordable Care Act (ACA), every once in a while an item comes along that nevertheless grabs my attention. The treatment of wellness plans at the hands of the Equal Employment Opportunity Commission (EEOC) is such an item.

The problem, put simply, is that without telling anyone what the rules are, the EEOC has begun to challenge a subset of popular wellness programs, the design of which is expressly sanctioned by the ACA. Of course, simply because a wellness program satisfies one Federal law does not mean that another may not also apply. A pension plan that satisfies ERISA, for example, may nevertheless fail to satisfy the tax qualification requirements of the Internal Revenue Code (the "Code"). What is different here is the insistence of the EEOC to push ahead with enforcement compliance while at the same time obstinately refusing (following a deluge of requests from industry and other groups as well as damning adverse judicial precedent) to issue regulations.

For a while it seemed that the EEOC, perhaps sensing that the lack of guidance put us at a disadvantage, limited its enforcement efforts to a handful of egregious cases, hoping perhaps that bad facts might make good law. But then came *EEOC v. Honeywell*, No. 0:14-04517 (D. Minn. 2014), where the EEOC took on a mainstream wellness program sponsored by Honeywell International, Inc. One can only imagine their surprise when Honeywell failed to roll over and instead decided to fight back. (We explain the particulars of these cases in previous posts available here and here.

Spoiler alert: things did not go well (at least so far) for the EEOC. And, despite that the case is only getting started, our sense is that the outcome will not fit the EEOC's picture of a raging success. In making this prediction, we don't for a moment claim that wellness programs raise no legitimate ADA issues. They do. Nor do we claim that the ACA's wellness program imprimatur should require the EEOC to abdicate its role as the ADA's principal enforcer. The EEOC shouldn't. But the EEOC's attempts to randomly enforce its views of how wellness programs should be regulated without telling anyone what the rules are strikes us as irresponsible—reminiscent of Dean Wormer's "double secret probation" imposed on the members of the Delta Tau Chi fraternity of *Animal House* fame.

Background

Wellness Programs Under the ACA

Wellness programs, at least those that form part of employer-sponsored group health plans, have become commonplace. While wellness programs can take a number of forms, and there are any number of programs, arrangements and schemes that fall under the heading of "wellness," the Affordable Care Act codified and expanded particular kinds of wellness plans that are the subject of a comprehensive final regulation issued by the Departments of Health and Human Services, Labor and Treasury/IRS.

The final regulations generally divide wellness programs into two categories. First, programs that do not require an individual to meet a standard related to a health factor in order to obtain a reward are not considered to discriminate under the HIPAA nondiscrimination regulations and therefore, are permissible without conditions under such rules ("participatory wellness programs"). Examples in the regulations include a (i) fitness center reimbursement program, (ii) diagnostic testing

program that does not base rewards on test outcomes, (iii) program that waives cost-sharing for prenatal or well-baby visits, (iv) program that reimburses employees for the cost of smoking cessation aids regardless of whether the employee quits smoking, and (v) program that provides rewards for attending health education seminars.

The second category of wellness programs under the final rules consists of health-contingent wellness programs, which may be either activity-only or outcome-based. Examples of health-contingent wellness programs include programs that (i) provide a reward to those who do not use, or decrease their use of, tobacco, or (ii) reward those who achieve a specified health-related goal, such as a specified cholesterol level, weight, or body mass index, as well as those who fail to meet such goals but take certain other healthy actions.

Wellness Programs Under the ADA

The ADA generally provides that it is unlawful for an employer "to discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." Under the ADA, it is unlawful for an employer to discriminate on the basis of disability in the provision of health insurance to their employees. According to the EEOC, decisions about the employment of an individual with a disability cannot be motivated by concerns about the impact of the individual's disability on the employer's health insurance plan. Moreover, employees with disabilities must be accorded "equal access" to whatever health insurance the employer provides to employees without disabilities.

The ADA also imposes limits on when an employer may make disability-related inquiries of employees or ask them to take medical examinations. In general, disability-related inquiries and medical examinations are permitted as part of a *voluntary* wellness program. According to the EEOC, *a wellness program is voluntary as long as an employer neither requires participation nor penalizes employees who do not participate*. At issue is whether a wellness program reward amounts to a requirement to participate, or whether withholding of the reward from non-participants constitutes a penalty, thus rendering the program involuntary. The EEOC has not taken a position on this question.

If a wellness program is voluntary, and if an employer requires participants to meet certain health outcomes or to engage in certain activities in order to remain in the program or to earn rewards, the ADA imposes on the employer a requirement to provide a reasonable accommodation, absent undue hardship, to those individuals who are unable to meet the outcomes or engage in specific activities due to a disability. A reasonable accommodation usually includes modifications and adjustments that enable employees to enjoy "equal benefits and privileges of employment."

In addition to the above-described rules governing voluntary benefit programs, the ADA contains a *separate* exception that permits employers, insurers, and plan administrators to establish and/or observe the terms of a group health plan that is "bona fide," based on "underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law," and that is not being used as a "subterfuge" to evade the purposes of the ADA. The EEOC claims that only insurance carriers do underwriting. Thus, only fully-insured plans may qualify. Statutory support for this proposition eludes us.

EEOC v Honeywell

On October 27, 2014, the EEOC filed for an injunction against Honeywell asserting that Honeywell violated the ADA by requiring participation in medical exams associated with Honeywell's group health plan and wellness program, which included a self-funded health reimbursement arrangement, when it provided financial inducements to incentivize participation. The wellness program that was the subject of the suit was pretty straightforward. Honeywell imposed a surcharge on an employee in instances in which the employee or the employee's spouse declined to undergo limited biometric testing associated with the wellness program. The EEOC claimed that the financial inducements violated both the ADA and, by including spouses, the Genetic Information Nondiscrimination Act ("GINA"). On November 3, 2014, the court denied the EEOC's motion based on the EEOC's failure to show any irreparable harm.

NOTE: With respect to GINA, the EEOC is taking the position that a spouse's personal medical history is family medical history with respect to the employee. As a result, the personal medical history of the spouse is "genetic information" for purposes of Title II of GINA. According to the EEOC's brief in Honeywell, "[u]nder GINA, employers are prohibited from offering incentives to an employee in order to obtain family medical history in connection with a wellness program."

Previous EEOC enforcement actions

Earlier this year, EEOC filed two lawsuits involving wellness programs, *EEOC v. Flambeau*, Inc., No. 3:14-00638 (W.D. Wis. 2014), and *EEOC v. Orion Energy Systems, Inc.*, No. 1:14-01019 (E.D. Wis. 2014). In both cases, the EEOC claimed that the wellness programs at issue violated Title I of the ADA because they required employees to submit to involuntary medical examinations that were neither job-related nor consistent with business necessity. Without going into the particulars, suffice it to say that the wellness programs in these latter two cases seemed excessive. For example, in Orion's case, employees who participated in a wellness program that required completion of a health risk assessment (including blood work) had coverage provided free of any cost, while those who failed to do so were required to pay the full cost of the premiums plus an additional penalty.

Seff v. Broward County

While the EEOC was not a party, a case arising in Florida decided by the U.S. Court of Appeals for the Eleventh Circuit vastly complicates the EEOC's efforts. The case, *Seff v. Broward County*, 692 F.3d 1221 (11th Cir. 2012), involved a wellness program maintained by Broward County, Florida, which offered a bimonthly $20 premium discount to employees who completed a health risk assessment that included a "finger-stick" blood test. The Court held that this Broward County arrangement did not violate the ADA. Specifically, the court concluded that the program fit within the ADA safe harbor for plans that are based on sound underwriting and classifying of risk principles and that were not otherwise a "subterfuge" for disability discrimination. This holding is significant as a plan that fits under this exception need not worry about meeting any standards relating to voluntariness.

NOTE: In its brief, the EEOC claimed that Broward was wrongly decided since there was no evidence of underwriting. This looks right to us. But Honeywell does not appear to have made this mistake. Thus, in *Honeywell*, the EEOC was pretty much forced to argue, as we note above, that only insurers do underwriting.

What's Wrong with this Picture?

With the ACA, Congress sought to encourage the use of wellness programs through financial incentives. With the ADA, Congress sought to limit the extent to which employers are permitted to make disability-related inquiries of their employees. While the ACA rules don't inform the enforcement of the ADA, it makes little sense to read these rules as entirely contradictory. Continuing on the pension example, the Code does not bar the adoption and maintenance of an ERISA-regulated pension plan; rather, it adds a layer of tax requirements intended to broaden participation and place a cap on the net pension tax expenditure.

It seems to us that the best way to reconcile the ADA and the ACA is to use the ADA exceptions either for "voluntary" wellness programs or for those that are bona fide in nature and that satisfy basic underwriting standards. As the courts strive to read the two statutes consistently to the extent reasonably possible, we fully expect that they will take this route.

We understand that the EEOC has opened up a formal investigation of the Honeywell wellness program, which will likely take some time to resolve. The EEOC has also announced that it will issue proposed regulations "implementing the final [HIPAA] rules concerning wellness program incentives" as early as February 2015. While the prospect of rulemaking is a welcome development, we fully expect that the Honeywell matter will end up back in Federal Court, absent a change of heart on the part of the EEOC. Frank C. Morris, Jr., August Emil Huelle, and Adam C. Solander of Epstein Becker & Green, P.C. have penned a thoughtful analysis of how employers might proceed in the interim.

Tags: ACA, ADA, Affordable Care Act, Americans with Disabilities Act, EEOC, Equal Employment Opportunity Commission, ERISA, Genetic Information Nondiscrimination Act, GINA, health-contingent wellness programs, Honeywell, Internal Revenue Code, IRC, participatory wellness programs, voluntary wellness program, wellness programs

The Affordable Care Act—Countdown to Compliance for Employers, Week 5: Health and Human Services (HHS) Wastes No Time Issuing Proposed Rules Modifying Minimum Value Rules

Posted By Michael Arnold on November 24th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written By Alden J. Bianchi and Edward A. Lenz

Over the last couple of months, we have followed and reported on a particular ACA compliance strategy under which an employer subject to the Affordable Care Act's employer shared responsibility (or "pay-or-play") rules satisfies the requirement to make an offer of coverage under a group health plan that has the look-and-feel of major medical coverage with one significant modification: the plan offers no inpatient hospital coverage or physician services. (For a discussion of the development of these plans, please see our previous posts of September 16, October 14 and November 10.) Following the convention established by promoters of these arrangements, we refer to these arrangements as "minimum value plans" or "MVP arrangements." Because the monthly premium cost of MVP plans is far less expensive than the cost of traditional major medical coverage that includes inpatient hospital services or physician services, the cost to the employer to make such coverage affordable—and thereby avoiding exposure for assessable payments—is also lowered significantly.

In the weeks prior to November 4, various national news outlets reported that the regulators were less than thrilled with the MVP approach.

The problem—for the regulators, however—is that the regulatory structure that enabled MVP plans was of their own making. (Well, o.k., the statute might have had something to do with it.) With Notice 2014-69, HHS and the Treasury Department made it official: HHS regulations implementing minimum value standards would be revised to put MVP arrangements off limits. A few short weeks later, on November 21, HHS issued a proposed regulation doing just that. An advance copy of the proposed (324-page) regulation, entitled *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, is available here. The actual rule will be published in the Federal Register on November 26, 2014 (and will be available here).

Background

Under Internal Revenue Code § 36B, low and moderate income individuals may qualify for a premium tax credit to assist with the purchase of a qualified health plan from a public exchange or marketplace. The credit is not available, however, to individuals who have other coverage that qualifies as "minimum essential coverage" or "MEC." (The term "MEC" is potentially confusing, since it refers to the *source* of the other coverage, not its content.) An employer-sponsored group health plan is MEC, but for purposes of the premium tax credit an employee is generally treated as not eligible for MEC under an employer-sponsored plan unless the plan is affordable and provides minimum value (MV).

An employer-sponsored plan provides MV only if the plan's "share of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent of the costs." An employee who is eligible for coverage under an employer-sponsored plan that is both affordable and provides MV to the employee may not receive a premium tax credit. If the employer coverage does not provide MV, the employee may be entitled to a premium tax credit even if the coverage is affordable.

Under Code § 4980H, an applicable large employer (generally, an employer with 50 or more full-time and full-time equivalent employees during the previous calendar year) that does not offer coverage that is affordable and provides MV may be liable for an assessable payment (i.e., a non-deductible excise tax).

The Act delegates to HHS the task of prescribing MV rules for purposes of Code § 36B (relating to premium tax credits) and Code § 4980H (relating to employer shared responsibility). For the purposes of determining whether an employer-sponsored plan meets the 60% minimum threshold share of total costs, previously issued HHS final regulations define the percentage of the total allowed costs of benefits as (1) the anticipated covered medical spending for EHB coverage paid by a health plan for a standard population, (2) computed in accordance with the plan's cost sharing, and (3) divided by the total anticipated allowed charges for EHB coverage provided to the standard population. Shortly after, the Treasury Department/IRS published proposed regulations that refer back to the HHS final regulation. The final HHS regulations and proposed Treasury regulations allow plans to determine the MV percentage by using an on-line MV Calculator published by HHS. It is the HHS on-line calculator, sanctioned by a final regulation (i.e., a regulation that has the full force of law), that gave rise to the MVP plan. Not only does the calculator allow a plan to "uncheck" and thereby exclude inpatient hospital benefits, it is possible to get to 60 percent MV without covering inpatient hospital benefits.

The Brief Against MVP Arrangements

The preamble to the recently proposed rule states the problem thus—

"It has come to our attention that certain group health plan designs that provide no coverage of inpatient hospital services are being promoted, and that representations are being made, based on the MV Calculator, that these plan designs cover 60 percent of the total allowed costs of benefits provided under the plans and thus provide MV. We understand that these designs have been promoted as a way of both minimizing the cost of the plan to the employer (a consequence not only of excluding inpatient hospitalization benefits but also of making an offer of coverage that a substantial percentage of employees will not accept) and avoiding potential liability for employer shared responsibility payments. Employers adopting these plan designs seek, by offering coverage that is affordable to the employee and that purports to provide MV, to deny their employees the ability to obtain a premium tax credit that could result in the employer becoming subject to a section 4980H employer shared responsibility payment."

HHS correctly notes that the Act's rules requiring individual market and small group health insurance plans to cover 10 specified categories of benefits, referred to as "essential health benefits" or "EHB", do not apply to large fully-insured groups and self-funded arrangements. In the preamble to the newly proposed regulations, however, HHS asserts that the "MV standard may be interpreted to require that employer-sponsored plans cover critical benefits is evident in the structure of the Affordable Care Act, the context in which the grant of the authority to the Secretary to prescribe regulations under section 1302 was enacted, and the policy underlying the legislation." To get to this result, HHS reasoned as follows: EHBs must include at least 10 specified categories of benefits, and that the benefits be "equal to the scope of benefits provided under a typical employer plan." They also suggest that "any meaningful standard of minimum coverage may require providing certain critical benefits." But just because large group market and self-insured employers continue to have flexibility in designing their plans "does not mean that these plans should not be subject to minimum requirements." HHS concludes:

"A plan that excludes substantial coverage for inpatient hospital and physician services is not a health plan in any meaningful sense and is contrary to the purpose of the MV requirement to ensure that an employer-sponsored plan, while not required to cover all EHB, nonetheless must offer coverage with minimum value at least roughly comparable to that of a bronze plan offered on an Exchange."

Or, put another way, even though the Act appears to provide otherwise, HHS asserts that it has the power to impose a benefit mandate by regulation. We wonder about that. But even if the Act does not give HHS a conclusive warrant to impose an inpatient hospital requirement in the large group and fully-insured markets, it likely provides a sufficient basis to deter a serious challenge. Nor are we advocating a different outcome. MVP arrangements clearly provide less than optimal coverage and HHS has likely reached the right policy result. Our concern is not with the policy but with the parsimonious transition rule discussed below.

The Fate of the On-Line Calculator

As we note above, the on-line calculator enabled the MVP design, which HHS unequivocally acknowledges:

"Employers have been able to claim that plans without coverage of inpatient hospital services provide MV under the current quantitative MV test by designing a benefit package that, based on standardized actuarial assumptions used in the MV calculator, offsets the absence of actuarial value derived from spending on inpatient hospital coverage with increased spending on other benefits. *Accordingly, some plan designs may pass the current quantitative test without offering a critical benefit universally understood to be included in any minimally acceptable employer health plan coverage, and which the Department of Labor study determined was included in all employer plans it surveyed*." (Emphasis added.)

Put another way, *under current law, MVP arrangements provide MV*. They do so by offsetting the loss in actuarial value caused by the absence of inpatient hospital coverage by increased spending on other benefits. A necessary corollary is that employers who adopted MVP arrangements to minimize costs and avoid assessable tax payments acted both reasonably and lawfully. The purpose certainly was not, as HHS implies, "to deny their employees the ability to obtain a premium tax credit." That was a byproduct, not the purpose, of the arrangements.

The Proposed Fix

HHS has determined that plans that omit inpatient hospital services fail to meet universally accepted minimum standards of value expected from, and inherent in the nature of, any arrangement that can reasonably be called a health plan intended to provide the primary health coverage for employees. Toward this end they propose to add an additional, qualitative requirement. Specifically, HHS has proposed to amend its final MV regulations to require that, in order to provide minimum value, an employer-sponsored plan not only must meet the quantitative standard of the actuarial value of benefits, but also must provide a benefit package that meets a minimum standard of benefits. Moreover, in order to satisfy MV, an employer plan must provide substantial coverage of both inpatient hospital services and physician services. HHS has invited comments on ways to determine whether a plan has offered "substantial" benefits.

The Transition Rule

HHS proposes that the changes to its MV final regulations will apply to employer-sponsored plans, *including plans that are in the middle of a plan year*, immediately on the effective date of the final regulations. Because some employers adopted plans prior to publication of Notice 2014-69, HHS further proposes that the final regulations not apply before the end of the plan year (as in effect under the terms of the plan on November 3, 2014) to plans that "before November 4, 2014, entered into a binding written commitment to adopt, or began enrolling employees into, the plan, so long as that plan year begins no later than March 1, 2015." The preamble to the proposed regulation clarifies that, "[f]or these purposes, a binding written commitment exists when an employer is contractually required to pay for an arrangement, and a plan begins enrolling employees when it begins accepting employee elections to participate in the plan."

This is an unnecessarily stingy transition rule. Notice 2014-69 came out a mere 7 weeks from the general effective date of the employer shared responsibility rules. Many employers were well along the road to implementing an MVP arrangement, but had not yet signed the contract, and their anticipated open enrollment was just weeks away. Some employers delayed signing agreements when news reports first surfaced that the regulators might do "something." Their caution has been rewarded with a loss of transition rule status weeks before the employer responsibility rules go into effect. The proper standard for transition relief, in our view, should be "substantial progress toward adoption" or something to that effect. Such a standard might be marginally harder to audit, but regulators are not here seeking to remedy an abuse. They are fixing a problem of their own making.

Tags: ACA, Affordable Care Act, Code § 36B, Code § 4980H, HHS, IRS, MEC, minimum essential coverage, minimum value, minimum value plans, MVP, pay-or-play rules, Treasury Department

The Affordable Care Act—Countdown to Compliance for Employers, Week 6: Labor and Treasury Departments Play Whack-a-Mole with Employer Payment Plans

Posted By Michael Arnold on November 17th, 2014 | Posted in ACA Compliance Series, Affordable Care Act

Written by Alden J. Bianchi

Last year, the Department of Labor and the Treasury Department/IRS (Departments) issued guidance on the application of certain of the Affordable Care Act's insurance market reforms to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements. For an explanation of this guidance, please see our client advisory dated September 25, 2013. The Departments issued further clarifications in May of this year, which we covered in a previous post. Collectively, these guidance items addressed plan designs in which employers attempt to subsidize the purchase of health insurance coverage (whether on a pre-tax or after-tax basis) in the individual market (whether or not under a qualified health plan offered through a public exchange).

In each of these pronouncements, the Departments clarified that arrangements of all stripes that seek to provide cash subsidies for the purchase of individual market coverage are themselves group health plans subject to the Act's insurance market reforms and other requirements. As a consequence, schemes claiming that employers can comply with the Act by simply providing cash subsidies do not work as advertised. Despite the Department's efforts, a handful of promoters have consistently failed to get, or have purposely chosen to ignore, the proverbial memo. A recent set of FAQs makes short shrift of two arrangements—after tax subsidies and a pre-tax reimbursement arrangement—that are on solid regulatory ground. These arrangements are not now and never were (in our view) viable, and their promotion was both reckless and irresponsible. The Departments' treatment of a third arrangement—giving employees with high claims risk a choice between group health plan enrollment or cash—is well-intentioned and may even be the "right" result. But it rests (again in our view) on less solid legally and regulatory ground.

Set out below are the FAQs' questions together with our reaction:

Question 1: My employer offers employees cash to reimburse the purchase of an individual market policy. Does this arrangement comply with the market reforms?

Notice 2013-14 made it abundantly clear that certain pre-tax arrangements (i.e., health reimbursements accounts (HRAs) and health flexible spending accounts (health FSAs) used to fund the purchase of individual market health coverage—referred to generically as "employer payment plans"—run afoul of the Act's bar on annual and lifetime limits and preventive services mandate. But an employer payment plan does not include an arrangement under which "an employee may choose either cash or an after-tax amount to be applied toward health coverage," provided that the arrangement qualifies as a payroll practice. A "payroll practice" for this purpose is defined with reference to applicable Department of Labor regulations (29 C.F.R. §2510.3-1(j)).

An arrangement that qualifies as a payroll practice is not treated as a group health plan and thus is not subject to the ACA's insurance market reforms. Some folks missed the implication of the "payroll practice" requirement, which permits an employer to provide a choice between *unrestricted* after-tax cash and health coverage. But an offer of after-tax cash that is conditioned on the purchase of health coverage is itself a group health plan that is itself subject to, and will run afoul of, certain of the ACA's insurance market and other requirements.

Q2: My employer offers employees with high claims risk a choice between enrollment in its standard group health plan or cash. Does this comply with the market reforms?

Moving participants with expensive health conditions off of an employer's group health plan and onto a public exchange or other individual market coverage has the potential to destabilize the insurance markets. Congress took no steps in the Affordable Care Act or elsewhere, however, to expressly ban this practice. In its 2006 health care reform law, the Massachusetts legislature took the opposite tact by expressly barring individuals with access to employer coverage from enrolling in coverage under the state's public insurance marketplace. As a consequence, it seems to us that this is a problem for Congress to fix, not the Departments.

A legislative fix is impossible given the current political environment, particularly in light of the results of the 2014 mid-term elections. So the Departments have tackled the problem using existing law and regulations. The particular lever that the Departments choose for the task is ERISA § 702 and Code § 9802, which were originally added by the Health Insurance Portability and Accountability Act (HIPAA). These statutory provisions prohibit discrimination based on one or more health factors. According to the Departments, "offering, only to employees with a high claims risk, a choice between enrollment in the standard group health plan or cash," constitutes such discrimination. The problem for the Departments is that their current regulations permit more favorable rules for eligibility or reduced premiums or contributions based on an adverse health factor (sometimes referred to as benign discrimination). So in the Q&As the Departments had to explain why this particular species of benign discrimination is discriminatory—for which they provide the following reasons:

1. The offer of a choice of additional cash or enrollment in the employer's plan to a high-claims-risk employee does not reduce the amount charged to the employee with the adverse health factor. The offer instead effectively increases the premium or contribution the employer's plan requires the employee to pay for coverage, because the high-claims-risk employee must accept the cost of forgoing the cash in order to elect plan coverage.

   Seriously? The employee ends up with coverage through a public exchange or marketplace under a plan that covers all 10 essential health benefits (a requirement to which the employer's plan is not subject). So the employee gets the better of one or the other. This choice might be particularly valued by an employee who requires a very high-cost specialty prescription drug not covered under the employer's plan. Where, one might ask, is the increased cost to the employee?

2. The current regulations that permit benign discrimination allow for benefits enhancements but not cash. For example, a plan may have an eligibility provision that provides coverage to disabled dependent children beyond the age at which non-disabled dependent children become ineligible for coverage. But providing cash as an alternative to health coverage for individuals with adverse health factors is an eligibility rule that discourages participation in the group health plan.

   And the problem with this is? Where coverage is preserved under either the employer's plan or a public market place using an approach that Congress could have easily prevented but chose not to, why is it a problem that participation in the employer's group health plan might be discouraged at the margins?
3. The Departments rightly point out that the choice between taxable cash and a tax-favored qualified benefit must take the form of an election under a Code section 125 cafeteria plan, which could, depending on the facts and circumstances, result in discrimination in favor of highly compensated individuals. So this practice may not be available to individuals in the prohibited group.

At bottom, it strikes us that this is a policy rather than a regulatory matter. Nevertheless, there is all likelihood sufficient statutory authority for the Departments to impose the rule that is asserted in this FAQ. The statute speaks in terms of "discrimination based on health status." One can read "discrimination" narrowly to mean "to treat differently" such that benign discrimination is not permitted. But that is not how the regulators have historically treated discrimination.

Q3: A vendor markets a product to employers claiming that employers can cancel their group policies, set up a Code section 105 reimbursement plan that works with health insurance brokers or agents to help employees select individual insurance policies, and allow eligible employees to access the premium tax credits for Marketplace coverage. Is this permissible?

This compliance strategy is truly loopy. On its face, a "Code section 105 reimbursement plan" is clearly a group health plan, which is clearly subject to the Act's insurance market and other reforms. As such, the prohibition on annual limits and the requirement to provide certain preventive services without cost sharing would apply. According to the Q&A, "[t]hese arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate PHS Act sections 2711 and 2713, among other provisions, which can trigger penalties such as excise taxes under section 4980D of the Code." In addition, employees participating in such arrangements are ineligible for premium tax credits (or cost-sharing reductions) for marketplace coverage.

The Affordable Care Act—Countdown to Compliance for Employers, Week 7: IRS Puts the Kibosh on Health Plans that Fail to Cover Hospital or Physician Services

Posted By Michael Arnold on November 10th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

In a previous post, we described an Affordable Care Act compliance strategy—referred to commercially as a "minimum value plan" or "MVP"—that involves an offer of group health plan coverage that, while similar in most respects to traditional major medical coverage, carves out inpatient hospital services. A subsequent post warned of rumors that regulators were less than thrilled with these arrangements, and that in all likelihood the Treasury Department/IRS and the Department of Health and Human Services (the "Departments") would take steps to require that plans purporting to provide minimum value cover such services.

On November 3, 2014, the Departments announced their intent to retroactively revise their respective minimum value regulations so that plans that fail to provide substantial coverage for in-patient hospitalization services (or for physician services) will not qualify as minimum value. The Departments' announcement also included some limited transition relief, and imposed some additional notice requirements.

Background

An employer may be liable for an "assessable payment" under the Affordable Care Act's employer shared responsibility (pay-or-play) rules if one or more of its full-time employees receives a premium tax credit from a public exchange or marketplace. An employee (or family member) who is offered coverage under an eligible employer-sponsored plan that offers affordable coverage providing "minimum value," however, is barred from receiving a tax credit.

MVPs were intended to facilitate compliance by employers by lowering the cost of affordable, minimum value coverage. The plans hold down costs by carving out in-patient hospitalization services or, in some cases, physician services, while at the same time providing minimum value. By offering affordable MVP coverage to substantially all their full-time employees, an employer would avoid penalties under the ACA's employer shared responsibility rules.

The Actuarial Assumptions underlying "minimum value"

In general, a plan provides minimum value if the plan's "share of the total allowed costs of benefits provided under the plan is at least 60 percent of the total allowable cost of benefits"— defined in regulations published by the U.S. Department of Health and Human Services as:

1. The anticipated covered medical spending for a bundle of services referred to as "essential health benefits" (EHBs);
2. Computed in accordance with the plan's cost-sharing, and
3. Divided by the total anticipated allowed charges for EHB coverage provided to a standard population.

While EHBs include in-patient hospital services and physician services, self-funded and large fully-insured employer-sponsored group health plans are not required to offer EHBs and thus are not required to provide these services. The regulators worried, however, about the reference in the ACA to coverage offered to a "standard population." In this context, the standard population that Congress had in mind includes and is generally limited to large employer plans. According to the Departments:

"A plan that fails to provide substantial coverage for these services would fail to offer fundamental benefits that are nearly universally covered, and historically have been considered integral to coverage, under typical employer-sponsored group health plans."

In May 2013, the IRS published a proposed regulation that looked to the HHS standards to determine minimum value. According to the IRS, if a plan provided minimum value for HHS's purposes (principally to determine whether individuals were eligible for a premium tax credit), then the plan was also deemed to provide minimum value for purposes of determining assessable payments under the employer shared responsibility rules. Under the HHS final regulations and the IRS's proposed rule, plans can determine minimum value by, among other approaches, using an on-line calculator designed and made available by HHS.

It did not take long for sponsors and promoters of MVP arrangements to discover that a group health plan could, if properly designed, return a value of 60% from the online calculator even if the plan did not cover inpatient hospital services or physician services. This design proved particularly attractive since exclusion of inpatient hospital services or physician services reduced the premiums for MVP coverage to less than half of the cost of traditional major medical coverage, making it much easier for employers to offer MVP coverage on an affordable basis.

The Problem with the Calculator

Notice 2014-69 states flatly that plans that fail to provide substantial coverage for in-patient hospitalization services should not be permitted to satisfy the requirements for providing minimum value. In so holding, the notice concedes that that there may be a problem under the hood of the online calculator. According to the notice:

"Concerns have been raised as to whether the continuance tables underlying the MV Calculator (and thus the MV Calculator) produce valid actuarial results for unconventional plan designs that exclude substantial coverage for in-patient hospitalization services. These concerns include that the standard population and other underlying assumptions used in developing the MV Calculator and associated continuance tables are based on typical self-insured employer-sponsored plans, essentially all of which historically have included coverage for these services, and that designing a plan to exclude such coverage could substantially affect the composition of the population covered by discouraging enrollment by employees who have, or anticipate that they might have, significant health issues. It has been suggested that these and other effects resulting from excluding substantial coverage of in-patient hospitalization services may not be adequately taken into account by the MV Calculator and its underlying continuance tables. Similar concerns have been raised regarding the possibility of using the MV calculator to demonstrate that an unconventional plan design that excludes substantial coverage of physician services provides minimum value."

In plain English, government actuaries have a lot of work ahead of them to figure out exactly how the online calculator should be reconfigured to produce the intended policy result of requiring hospital and physician coverage, and what the scope of that coverage should be.

Treatment of MVP Arrangements in 2015 and Later Years

In Notice 2014-69, the Departments announced their intent to revise their respective minimum value regulations so that plans that fail to provide substantial coverage for in-patient hospitalization services or for physician services will not qualify as minimum value. The Departments anticipate that these changes will be finalized in 2015 and will generally apply beginning in 2015, with one important exception.

Transition Relief

Recognizing that many employers have either already adopted or have gone a long way toward adopting MVP-type arrangements, the notice provides a welcome transition rule under which a plan that is adopted before November 4, 2014 and that has a plan year beginning no later than March 1, 2015 will not be subject to the new rules until the following plan year. This transition rule applies to an employer that has either "entered into a binding written commitment to adopt, or has begun enrolling employees in, [an MVP arrangement] prior to November 4, 2014 based on the employer's reliance on the results of use of the MV Calculator."

Employers that have at least some written evidence, prior to November 4, 2014 of a binding commitment to adopt an MVP plan should qualify for relief. With respect to starting enrollment, circulation of enrollment materials clearly qualifies. Arguably, notifying employees that the enrollment will commence at some time in the near future also should qualify.

Employers unsure of whether they have taken sufficient steps prior to November 4, 2014 to qualify for relief should consult their insurance advisors or legal counsel.

Employer Duty to Inform Employees

Irrespective of whether an MVP arrangement qualifies for transition relief, the Departments have determined that employees covered under MVP arrangements will retain their eligibility for premium tax credits even though the employer is protected from assessable payments. Notice 2014-69 imposes on employers that offer coverage under MVP arrangements the obligation to refrain from making certain representations and to make certain affirmative disclosures. Specifically, the employer—

- Must not state or imply in any disclosure that the offer of coverage under the MVP arrangement precludes an employee from obtaining a premium tax credit, if otherwise eligible; and
- Must timely correct any prior disclosures that stated or implied that the offer of the MVP arrangement would preclude an otherwise tax-credit-eligible employee from obtaining a premium tax credit.

The notice further clarifies that if an employer also offers an employee another plan that is not an MVP arrangement and that is affordable and provides minimum value, the employer is permitted to advise the employee that the offer of this other plan will or may preclude the employee from obtaining a premium tax credit.

Closing Thoughts

Notice 2014-69 appears to impose a benefit mandate—i.e., to cover inpatient hospital services and physician services—on self-funded and large fully-insured group health plans. The Departments might claim that this is not a benefit requirement, since no plan is required to include inpatient hospital services and physician services. It is rather a predicate for minimum value status. This can only be true, however, if there is a problem under the hood of the calculator. *Is it really possible for a plan that fails to cover inpatient hospital services and physician services to deliver a minimum value of 60% or greater*? If the answer is yes, then it should not be possible for the Departments to deliver on their promise. While the notice does not say so explicitly, one suspects that they have already determined that an MVP plan cannot get to 60% minimum value.

Tags: ACA, Affordable Care Act, assessable payment, Department of Health and Human Services, EHBs, essential health benefits, IRS, IRS Notice 2014-69, minimum value plan, MV Calculator, MVP, Treasury Department

The Affordable Care Act—Countdown to Compliance for Employers, Week 8: Breaking HPID News

Posted By Michael Arnold on November 2nd, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

In a surprise move, the Centers for Medicare & Medicaid Services (CMS) announced an indefinite delay in enforcement of regulations pertaining to "health plan enumeration and use of the Health Plan Identifier (HPID) in HIPAA transactions" that would have otherwise required self-funded employer group health plans (among other "covered entities") to take action as early as November 5, 2014.

The CMS statement reads as follows:

Statement of Enforcement Discretion regarding 45 CFR 162 Subpart E – Standard Unique Health Identifier for Health Plans

Effective October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) Office of E-Health Standards and Services (OESS), the division of the Department of Health & Human Services (HHS) that is responsible for enforcement of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard transactions, code sets, unique identifiers and operating rules, announces a delay, until further notice, in enforcement of 45 CFR 162, Subpart E, the regulations pertaining to health plan enumeration and use of the Health Plan Identifier (HPID) in HIPAA transactions adopted in the HPID final rule (CMS-0040-F). This enforcement delay applies to all HIPAA covered entities, including healthcare providers, health plans, and healthcare clearinghouses.

On September 23, 2014, the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS, recommended that HHS rectify in rulemaking that all covered entities (health plans, healthcare providers and clearinghouses, and their business associates) not use the HPID in the HIPAA transactions. This enforcement discretion will allow HHS to review the NCVHS's recommendation and consider any appropriate next steps.

The CMS statement followed, but was not anticipated by, a recent series of FAQs that provided some important and welcome clarifications on how employer-sponsored group health plans might comply with the HPID requirements.

Background

Congress enacted the HIPAA "administrative simplification" provisions to improve the efficiency and effectiveness of the health care system. These provisions required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions and code sets, unique health identifiers, and security. As originally enacted, HIPAA directed HHS to establish standards for assigning "unique health identifiers" for each individual, employer, health plan, and health care provider. The Affordable Care Act modified and expanded these requirements to include an HPID. On September 5, 2012, HHS published final regulations adopting HPID enumeration standards for health plans ("enumeration" is the process of getting an HPID).

For the purposes of HPID enumeration, health plans are divided into controlling health plans (CHPs) and sub-health plans (SHPs). Large CHPs (i.e., those with more than $5 million in annual claims) would have been required to obtain HPIDs by November 5, 2014. Small controlling health plans had an additional year, until November 5, 2015.

The Issue(s)

While we have no idea what led the NCVHS to recommend to CMS that it abruptly suspend the HPID rules, we can make an educated guess—two guesses, actually.

What is it that is being regulated here?

The HIPAA administrative simplification rules apply to "covered entities." i.e., health care providers, health plans, and health care data clearing houses. Confusingly, the term "health plan" includes both group health insurance sponsored and sold by state-licensed insurance carriers and employer-sponsored group health plans. Once HHS began issuing regulations, it became apparent that this law was directed principally at health care providers and health insurance issuers or carriers. Employer-sponsored group health plans were an afterthought. The problem for this latter group of covered entities is determining what, exactly, is being regulated. The regulatory scheme treats an employer's group health plan as a legally distinct entity, separate and apart from the employer/plan sponsor. This approach is, of course, at odds with the experience of most human resource managers, employees and others, who view a company's group health plan as a product or service that is "outsourced" to a vendor. In the case of an insured plan, the vendor is the carrier; in the case of a self-funded plan, the vendor is a third-party administrator.

The idea that a group health plan may be treated as a separate legal entity is not new. The civil enforcement provisions of the Employee Retirement Income Security Act of 1974 (ERISA) permit an "employee benefit plan" (which includes most group health plans) to be sued in its own name. (ERISA § 502(d) is captioned, "Status of employee benefit plan as entity.") The approach taken under HIPAA merely extends this concept. But what exactly, is an "employee benefit plan?" In a case decided in 2000, the Supreme Court gave us an answer, saying:

"One is thus left to the common understanding of the word 'plan' as referring to a scheme decided upon in advance . . . Here the scheme comprises a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." (*Pegram v. Herdrich*, 530 U.S. 211, 213 (2000).)

Thus, what HHS has done in the regulations implementing the various HIPAA administrative simplification provisions is to impose rules on a set of promises and an accompanying administrative scheme. (Is there any wonder that these rules have proved difficult to administer?) The ERISA regulatory regime neither recognizes nor easily accommodates CHPs and SHPs. The FAQs referred to above attempted to address this problem by permitting plan sponsors to apply for one HPID for each ERISA plan even if a number of separate benefit plan components (e.g., medical, Rx, dental, and vision) are combined in a "wrap" plan. It left in place a larger, existential problem, however: It's one thing to regulate a covered entity that is a large, integrated health care system; it's quite another to regulate a set of promises. The delay in the HPID enumeration rules announced in the statement set out above appears to us to be a tacit admission of this fact.

Why not permit a TPA to handle the HPID application process?

One of the baffling features of the recently suspended HPID rules is CMS' rigid insistence on having the employer, in its capacity as group health plan sponsor, file for its own HPID. It was only very recently that CMS relented and allowed the employer to delegate the task of applying for an HPID for a self-funded plan to its third party administrator. By cutting third party administrators out of the HPID enumeration process, the regulators invited confusion. The reticence on CMS' part to permit assistance by third parties can be traced to another structural anomaly. While HIPAA views TPAs in a supporting role (i.e., business associates), in the real world of self-funded group health plan administration, TPAs function for the most part autonomously. (To be fair to CMS, complexity multiplies quickly when, as is often the case, a TPA is also a licensed carrier that is providing administrative-services-only, begging the question: Are transmissions being made as a carrier or third party administrator?)

HIPAA Compliance

In last week's post, we alluded to the need of employers new to self-funding to be aware of the HIPAA privacy and security compliance burdens that they are taking on. That the HPID enumeration rules have been delayed does not mean that employers which sponsor self-funded plans have nothing to do. The HIPAA privacy rule imposes on covered entities a series of requirements that must be adhered to. These include the following:

- **Privacy Policies and Procedures.** A covered entity must adopt written privacy policies and procedures that are consistent with the privacy rule.

- **Privacy Personnel.** A covered entity must designate a privacy official responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.
- **Workforce Training and Management.** Workforce members include employees, volunteers, and trainees, and may also include other persons whose conduct is under the direct control of the covered entity (whether or not they are paid by the entity). A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions. A covered entity must also have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Rule.
- **Mitigation.** A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.
- **Data Safeguards.** A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure.
- **Complaints.** A covered entity must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Rule. The covered entity must explain those procedures in its privacy practices notice. Among other things, the covered entity must identify to whom individuals at the covered entity may submit complaints and advise that complaints also may be submitted to the Secretary of HHS.
- **Retaliation and Waiver.** A covered entity may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule. A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.
- **Documentation and Record Retention.** A covered entity must maintain, until six years after the later of the date of their creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that the Privacy Rule requires to be documented.

The HIPAA security rule requires covered entities to conduct a risk assessment, and to adopt policies and procedures governing two dozen or so security parameters.

Tags: ACA, Affordable Care Act, CMS, Department of Health & Human Services, ERISA, health plan enumeration, Health Plan Identifier, HHS, HIPAA, HPID, IRS, unique health identifiers

EMPLOYMENT MATTERS
A blog about current developments and issues in employment, labor and benefits law
MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

The Affordable Care Act—Countdown to Compliance for Employers, Week 9: Misunderstanding "Offer[s] of Coverage on Behalf of Another Entity"

Posted By Michael Arnold on October 27th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written By Alden J. Bianchi and Edward A. Lenz

Applicable large employers faced with the prospect of complying with the Affordable Care Act's employer shared responsibility rules must grapple with and understand what it means to make an offer of minimum essential coverage under an eligible employer-sponsored [group health] plan to their full-time employees. Final regulations implementing these rules determine an individual's status as an "employee" by applying the "common law" standard, the contours of which were examined in a previous post. Identifying an employer's common law employees in a two-party arrangement is a simple matter. But this is not always the case in three-party arrangements (i.e., those in which workers are hired from or through commercial staffing firms or professional employer organizations). Three-party arrangements invite the question—whose employee is it? Where the Act's employer shared responsibility rules are concerned, the answer to that question tells us *which* entity must make the requisite offer of coverage when assessing exposure for assessable payments.

The final regulations provide a special rule governing outsourced employees or "offers of coverage on behalf of other entities." This rule is welcome to be sure, but it also appears to be widely misunderstood, systematically over-utilized, and in a few cases subject to interpretations that (seem to us, anyway) stray pretty far from the text.

Background

Recognizing the unique challenges posed by three-party employment arrangements, the preamble to the final regulations explains the problem and introduces the regulatory solution as follows (79 Fed. Reg. p. 8,566 (Feb. 12, 2014)):

"[I]f certain conditions are met, an offer of coverage to an employee performing services for an employer that is a client of a professional employer organization or other staffing firm (in the typical case in which the professional employer organization or staffing firm is not the common law employer of the individual) . . . made by the staffing firm on behalf of the client employer under a plan established or maintained by the staffing firm, is treated as an offer of coverage made by the client employer for purposes of section 4980H. *For this purpose, an offer of coverage is treated as made on behalf of a client employer only if the fee the client employer would pay to the staffing firm for an employee enrolled in health coverage under the plan is higher than the fee the client employer would pay to the staffing firm for the same employee if the employee did not enroll in health coverage under the plan*. (Emphasis added).

The rule itself appears in Treas. Reg. § 54.4980H-4(b)(2), and it provides, again in relevant part, as follows:

For an offer of coverage to an employee performing services for an employer that is a client of a staffing firm, *in cases in which the staffing firm is not the common law employer of the individual and the staffing firm makes an offer of coverage to the employee on behalf of the client employer under a plan established or maintained by the staffing firm*, the offer is treated as made by the client employer for purposes of section 4980H only if the fee the client employer would pay to the staffing firm for an employee enrolled in health coverage under the plan is higher than the fee the client employer would pay the staffing firm for the same employee if that employee did not enroll in health coverage under the plan. (Emphasis added).

Neither the preamble nor the final regulations explain the rationale for the requirement of an additional fee. The backstory has it that the Treasury Department and the IRS were worried about giving a common law employer who neither offered

nor paid for coverage credit for Code § 4980H purposes for coverage provided by another entity. The rules governing offers of coverage by unrelated entities also apply to collectively bargained multiemployer plans, which too are offered by separate, unrelated legal entities but into which the common law employer makes contributions based on the terms of a bargaining or joiner agreement. There is, however, an important difference. While contributions to a multiemployer plan are set by the collective bargaining process, the final regulations offer no indication of what an appropriate additional fee might be in the context of a staffing firm or professional employer, or even how and when that fee must be assessed.

Application of the Rule

(1) *Is the rule being overused*?

Clients of staffing firms and professional employers in many cases are insisting on applying the rules governing third-party offers by contract, often without first asking whether the rule is applicable. Where a staffing firm is the common law employer of the workers that it places with its client, then there is no need to charge the added fee. In an earlier article, we explored this question at length. To vastly oversimplify our argument, we claim that in the vast majority of cases, contract and temporary employees placed by traditional staffing firms with client organizations are the common law employees of the staffing firm. In professional employer organizations, however, the opposite is true: in most cases the professional employer organization is not the common law employer. But concerns about "getting it wrong" have led many users of third-party staffing firms to insist on complying with the rule (despite the potential increase in cost) in all their contracts and arrangements.

There are of course instances in which, based on all of the facts and circumstances, a client organization has legitimate concerns over the proper classification of workers placed with the client. In these cases, it makes perfect sense to take advantage of the rule governing third-party offers of coverage. But there are, in our view, many more instances where the rule is clearly not needed. For example, there is little reason to believe that workers recruited by a staffing firm and placed in short-term or high-turnover assignments would be the common law employees of the client organization. Nor would we draw the line here, since employee tenure is but one of several factors involved in common law employer analysis and by no means determinative.

Past precedents show that "control" is the key. A handful of older IRS general counsel memoranda and private letter rulings (which can't be relied on) generally agree that the staffing firm is the employer, at least where the staffing firm exercises the degree of control typical of most temporary staffing arrangements. In fact, one recent federal appeals court found the requisite control factors even in a PEO arrangement – factors that are typical of non-PEO staffing arrangements. *Blue Lake Rancheria v. United States*, 653 F. 3d 1112 (9th Cir. 2011).

(2) *What is the proper amount of the additional fee*?

For the first few years following the Act, there arose a debate about the extent to which the costs of ACA compliance would be shifted to clients. Early on, clients appeared to resist the idea that they would need to shoulder these costs. But in the run up to 2015, when the employer shared responsibility rules take effect, there appears to have been a shift in attitude. Clients are generally willing to subsidize the costs of ACA compliance, but they are insisting that their staffing firms rein these costs in with smart compliance strategies, and they are demanding transparency in pricing.

The additional fee requirement gives staffing firms a basis to pass through at least some of the costs of compliance. At one end of the spectrum, the additional fee could equal the substantiated cost of compliance. At the other end, the additional fee could be a nominal amount per hour (or some other period). But to date, no standard has emerged to tell us how much the additional fee ought to be.

(3) *When and how should the fee be charged*?

To the question, "when and how should the additional fee be charged," there seem to be as many answers as there are staffing firms. The regulators, speaking informally and off the record, clearly envision a detailed accounting (e.g., line-by-line in periodic invoices). This approach would constitute a "gold standard" of compliance. A "silver" standard might involve charging an aggregate amount each billing cycle, not broken down by employee, that is subject to review by the client. (The staffing firm would still need to be able to demonstrate compliance on review or audit.) Another approach we have encountered simply adds a percentage increment to the hourly billing rate or load as a proxy for the fee. While we suppose that it is possible to fashion an argument for this approach based on the lack of detail in the rule, this is not an approach we would endorse.

Nor does it appear that the additional fee must be charged periodically. We are aware, for example, of instances in which the parties are planning to provide for a back-charge at the end of the year or some other fixed period that is correlated to the periodic billing cycle under the statement of work, contract or other arrangement.

Some client organizations have objected to the approach we dub the gold standard (i.e., line-by-line in periodic charges) based on their concerns that this level of detail would run afoul of the HIPAA privacy rules. The HIPAA privacy and security rules generally impose requirements on covered entities that include employer-sponsored group health plans. HIPAA does not regulate employers directly, but it does limit the instances in which the extent to which "protected health information" or "PHI" may be disclosed to employers. Where an item of information is determined to be PHI, certain steps are required in order for the plan to share information with the employer. But if the information in question is not PHI, HIPAA does not apply.

Enrollment and disenrollment information is PHI when held by a group health plan, but not when an employer performs the enrollment function. In this latter case, the employer acts on behalf of the employee and not on the plan. But even if one assumes that this exception is too narrow to accommodate compliance with the rule governing third-party coverage (a point we are unwilling to concede), it is still entirely possible to comply with the final Code § 4980H rules governing third-party group health plan coverage by following the HIPAA plan sponsor disclosure rules. These latter, HIPAA rules permit disclosures to the employer/plan sponsor for plan administration purposes. (Complying with the final Code § 4980H rules governing third-party group health plan coverage is in our view quintessentially administrative, since it is integral to the plan enrollment process.)

On another note relating to HIPAA, it appears that many staffing firms (among others) are gravitating toward Code § 4980H compliance solutions that involve self-funded group health plans. While HIPAA does not stand in the way for Code § 4980H purposes, it is worth keeping in mind that the HIPAA privacy and security rules impose a series of obligations directly on self-funded plans to which sponsors (read, employers) need to adhere.

Tags: ACA, Affordable Care Act, employer shared responsibility rules, HIPAA, IRS, offers of coverage on behalf of other entities, PEO, PHI, protected health information, Section 4980H, staffing agencies

The Affordable Care Act—Countdown to Compliance for Employers, Week 10: What's an Employer to Do (with Marketplace Notices)?

Posted By Michael Arnold on October 22nd, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Under the Affordable Care Act's employer shared responsibility rules, applicable large employers (those with 50 or more full-time and full-time equivalent employees on business days during the preceding calendar year) incur exposure for assessable payments under Internal Revenue Code § 4980H when an applicable premium tax credit or cost-sharing reduction is allowed or paid for one or more low- or moderate-income full-time employees who have been certified to the employer as qualifying for an advance premium tax credit under Code § 36B. The final Code § 4980H regulations refer to this certification as a "Section 1411 Certification," which is a reference to Act § 1411(a). This provision gives the Department of Health and Human Services ("HHS") the authority to determine whether individuals are eligible to enroll in qualified health plans through a public exchange and whether they are eligible for a premium tax credit.

While not perhaps immediately apparent, there are really two related though different reasons for making advance premium tax credit determinations:

- *Code § 36B*
  The purpose is to determine eligibility for advance payments of the premium tax credit and cost-sharing reductions. The question is whether an individual is eligible for an advance premium tax credit under Code § 36B.
- *Code § 4980H*
  The purpose is to determine whether an applicable large employer is subject to an assessable payment under Code § 4980H.

Act § 1411(f)(1) directs HHS (in consultation with other departments) to provide an appeals process relating to eligibility for advance payments of the premium tax credit and cost-sharing reductions under Code § 36B. Act § 1411(f)(2) provides for a "separate appeals process for employers who are notified . . . that [they] may be liable for a tax imposed by" Code § 4980H. This post deals with the latter determination—i.e., whether an applicable large employer is subject to an assessable payment under Code § 4980H.

Applicable large employers may be liable for assessable payments under Code § 4980H. This determination is generally made by a controlled group member (or "applicable large employer member." The preamble to the proposed §4980H regulations provides that an assessable payment will be—

"[P]ayable upon notice and demand and is assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68 of the Code." (78 Fed. Reg. p. 235, Jan. 2, 2013).

The IRS will determine the penalty amount (if any) of each applicable large employer member based on information provided under the Code § 6056 reporting rules.

In connection with the process of assessing and paying the excise tax imposed by Code § 4980H, the IRS plans to adopt procedures that ensure employers receive certification that one or more employees have received a premium tax credit. According to an IRS Q&A on the subject:

"The IRS will contact employers to inform them of their potential liability *and provide them an opportunity to respond* before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after the due date for employees to file individual tax returns for that year claiming premium tax credits and after the due date for applicable large employers to file the information returns identifying their full-time employees and describing the coverage that was offered (if any)." (Emphasis added).

The reference to "an opportunity to respond' refers to the second level of appeal cited above, i.e., the level of appeal that is related to Code § 4980H, and not the appeal relating to Code § 36B.

NOTE: Public exchanges may send the employer notices on an employee-by-employee basis as eligibility determinations are made, or they may send notices for groups of employees. For 2015, the HHS intends to issue employer notices in batches, beginning in spring 2015. See 78 Fed. Reg. 54,113 (Aug. 30, 2013).

Some employers may get hundreds, even thousands, of Section 1411 Certifications, many of which may relate to variable hour employees who have not yet reached (and may not ever reach) full-time status. In these cases, since the employee's full-time status is not relevant to eligibility, the employer would have no basis for appealing the certification at the time it is made. While the reporting rules are designed to recognize these employees for purposes of the assessable payment calculations, the process may not work perfectly. Thankfully, an employer may wait until the IRS contacts them to inform them of their potential liability to explain why a tax is not owed with respect to one or more employees. Thus, an employer may—but is not obligated—to appeal each and every Section 1411 Certification as it is received. Or, to put it another way, the employer is not prejudiced for failing to engage in the initial appeals process under Code § 36B.

The Affordable Care Act—Countdown to Compliance for Employers, Week 11: Rethinking ACA Compliance Strategies Involving Reference Pricing Models and "MVP" Arrangements

Posted By Michael Arnold on October 14th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Under the Affordable Care Act's rules governing employer shared responsibility—which are codified in Internal Revenue Code § 4980H—where an applicable large employer makes an offer of group health plan coverage that is both "affordable" and provides "minimum value" to substantially all of its full-time employees, the employer is not liable for assessable payments under Code § 4980H. (Final regulations under Code § 4980H are available here; and a set of Questions and Answers prepared by the IRS describing the final rules can be accessed here.)

In an effort to drive down the cost of complying with these rules, certain applicable large employers—principally those in industries in which coverage was not previously offered across-the-board to most, if not all, full-time employees—have sought less expensive ways to offer coverage that is both "affordable" and provides "minimum value." In an earlier post we described some of the emerging compliance strategies, which included the reference pricing models and "MVP arrangements" that some employers were considering.

Two recent developments, one in the form of a set of FAQs issued by the Departments of Health and Human Services, Labor and Treasury/IRS, and the other a mere (though troubling) rumor, may cause employers to reconsider both these approaches.

Reference pricing

Reference pricing refers to a strategy under which a plan will pay only a pre-determined amount for medical services—e.g., Medicare rates plus 20%. In an earlier set of Frequently Asked Questions, the Departments expressed concerns about reference pricing models. They worried that reference pricing approaches might be used as "a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers." For example, while the Act imposes limits on in-network cost-sharing, might amounts required to be paid in excess of a reference price in the case of a non-network provider (e.g., any provider that does not accept the reference price) be an indirect levy of an additional cost-sharing amount? Despite these concerns, the Departments permitted reference pricing models to go forward, while at the same time inviting public comment on whether additional rules were needed.

In a recent FAQ, the Departments revisited the subject of reference pricing in light of public comments, which included the following:

- Plans and issuers should be permitted to limit counting an individual's maximum out-of-pocket ("MOOP") costs exceeding the reference price towards the maximum out-of-pocket amounts only with respect to certain types of services (such as non-emergency services or routine procedures);
- Plan and health insurance issuers should be required to observe network adequacy and quality standards or procedures where less-than-full credit is given against the MOOP for non-preferred providers;
- Plans should be required to establish an exceptions process in certain circumstances to allow an enrollee's full cost sharing for non-reference based priced providers to count toward the MOOP.

In response, the Departments determined that:

"Pending issuance of future guidance, for purposes of enforcing the [MOOP] requirements . . . the Departments will consider all the facts and circumstances when evaluating whether a plan's reference-based pricing design (or similar network design) that treats providers that accept the reference-based price as the only in-network providers and excludes or limits cost-sharing for services rendered by other providers is using a reasonable method to ensure adequate access to quality providers at the reference price . . ."

The facts and circumstances that the Departments propose to evaluate include the type of service and what rules apply to MOOP determinations in the case of non-network providers. Thus, plans "should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs, and does not function as a subterfuge for otherwise prohibited limitations on coverage." In particular, the Departments express the view that "a reference-based price would not be considered reasonable with respect to emergency services." Nor may a reference price be applied to a non-grandfathered plan that involves a more restrictive network for emergency services. Plans must also have procedures relating to network adequacy, as well as an exceptions process that ensures access to quality services. The FAQ also imposes disclosure requirements, including the automatic provision of a list of services to which the pricing structure applies and information on the pricing structure exceptions process.

MVP arrangements

Essentially, an MVP arrangement is a major medical plan that does not cover inpatient hospital services. (We explain the MVP approach in an earlier post). The rumor mill has it that "the IRS does not like these plans, and it is planning to shut them down imminently." For this purpose, we understand "imminently" means sometime after the 2014 mid-term elections. The logic attributed to "the IRS" is that a properly structured MVP arrangement (i.e., one that is offered on an affordable basis) prevents an otherwise subsidy-eligible employee from turning down an employer's offer of coverage under an MVP arrangement and getting subsidized coverage under a plan offered by a public exchange or marketplace. This is, of course, accurate. (Curiously, rumor central also claims that there is less concern over so-called "MEC plans,"—that is, plans that cover only preventive services—since an otherwise subsidy-eligible employee can turn down his or her employer's offer of MEC coverage and get subsidized coverage from a public exchange.) Lastly, it has been reported that there is little sympathy for employers that purchased MVP arrangements since they (the employers that purchased MVP arrangements) should have had the good sense to know that the deal sounded "too good to be true."

Whether one accepts these rumors as substantially accurate, or whether one treats them as the straw horses that they might well be, we have some concerns:

- *Who says?*

The Affordable Care Act delegates to the Department of Health and Human Services (HHS), and not the IRS, the job of establishing rules governing minimum value. It is a final HHS rule that establishes the on-line MV calculator as an authoritative source of minimum value determinations. Of course, the Treasury Department and the IRS have jurisdiction over the manner in which the Act's employer shared responsibility rules are implemented, but that does not appear to include adopting a different definition of minimum value than the one that HHS prescribes. At a minimum, it would seem that HHS would need to change its final regulations (or the manner in which the calculator is coded) to help the IRS out.

- *Essential health benefits in the large group and self-funded markets*

Employer-sponsored group health plans are not required to offer essential health benefits (which include inpatient hospital benefits) unless they are health plans offered in the small group market. The preamble to the IRS's own proposed rule in the matter acknowledges as much, saying:

"The proposed regulations do not require employer-sponsored self-insured and insured large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to qualified health plans."

The real issue, and one would hope the basis on which the regulators might act in the matter of MVP arrangements, is not whether a plan must cover some particular category of essential health benefits such as inpatient hospital services. Such a test is inapposite. The question ought to be—is a plan that fails to provide some particular category of essential health

benefits, such as inpatient hospital services, thereby rendered unable from an actuarial perspective from reaching a 60% minimum value? Inpatient hospital services can be very expensive, to be sure; but they are also far less common than other procedures. Presumably, the continuance tables that underpin the HHS on-line calculator reflect this fact. Because the calculator is a black-box, however, we can't know that.

- *"Too good to be true . . ."*

The retort to this is simple and, in our view, compelling: if HHS wanted all minimum value plans to include inpatient hospital services, then why did it give us a check box (thereby making them optional)? Any suggestion that employers have acted in less than good faith is, in our view, specious.

In our previous posts on the subject, we have assumed that if the regulators did not like MVP arrangements, they had (and have) in their formidable regulatory firepower the weapons with which to vaporize them. We have not changed our view. However, promoters have designed and marketed plans relying on and following to the letter an HHS final rule and an HHS-provided on-line calculator, which employers have purchased in an effort to ease their regulatory compliance costs. No employer is required to do anything more than the law requires; and any employer that does risks putting itself at a competitive disadvantage relative to those that do not. We are now about 10 weeks from the date on which the employer shared responsibility rules take effect, and for which the open enrollment period is right around the corner. So while the regulators are free to change the rules, we think the case for transition relief is compelling.

The Affordable Care Act—Countdown to Compliance for Employers, Week 12: The Treatment of Unpaid Leaves of Absence Under the Look-back Measurement Method

Posted By Michael Arnold on October 6th, 2014 Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Final regulations implementing the Affordable Care Act's employer shared responsibility rules furnish employers with two alternative methods—the monthly measurement method and the look-back measurement method—for identifying full-time employees. (The Act's employer shared responsibility standards are codified in Internal Revenue Code § 4980H; the final regulations can be accessed here.) For each method, the final regulations provide standards governing breaks-in-service that are unique to Code section 4980H. For employers choosing to apply the look-back measurement method, the principle purpose of the break-in-services rules is to determine whether an employee, upon his or her return from a service break, may be treated as a "new employee" or a "continuing employee." The employee's status as a new or continuing employee governs when the employee must be offered group health plan coverage without exposing the employer to assessable payments under the Act's employer shared responsibility standards.

Generally, employees returning from a break-in-service of 13 weeks or more (26 weeks in the case of an educational institution) may be treated as newly hired. Alternatively, under a "rule of parity," an employer may treat a rehired employee who has had a break of at least four weeks as a new employee if the employee's break in service (with no credited hours of service) is longer than the employee's period of service immediately preceding the break in service. But if an employee's break in service is less than 13 weeks (or 26 weeks in the case of an educational institution), and the employee previously qualified for coverage during the then current stability period, he or she is treated, upon rehire or resumption of service, as a continuing employee to whom coverage must be offered by the first day of the following month.

What constitutes a break in service is determined based on "hours of service." The final regulations provide in this regard as follows:

"An employee who resumes providing services . . . after a period during which the employee was not credited with any hours of service may be treated as having terminated employment and having been rehired, and therefore may be treated as a new employee upon the resumption of services, *only if the employee did not have an hour of service* . . . for a period of at least 13 consecutive weeks immediately preceding the resumption of services." (Emphasis added). Treas. Reg. § 54.4980H-3(d)(6)(i).

The final regulations define the term "hour of service" as follows:

"The term hour of service means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; *and each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence*…" (Emphasis added). Treas. Reg. § 54.4980H-1(a)(24).

Thus, there is no break-in-service during a paid leave of absence for purposes of applying the rules governing look-back measurement periods. The final regulations also include rules governing "special unpaid leave" that includes FLMA leave, military leave and jury duty. Special unpaid leave is treated similarly to paid leave.

But what about an unpaid leave of absence (LOA) that is not special unpaid leave? How must this leave be treated for purposes of the look-back measurement method? That is, for unpaid LOAs longer than 13 weeks, when does the employee's full-time status end? The answer controls when the employer need no longer continue making an offer of coverage to affected employees.

The final regulations make clear that the break-in-service rules described above apply—

"solely for the purpose of determining whether the employee, upon the resumption of services, is treated as a new employee or as a continuing employee, and does not determine *whether the employee is treated as a continuing full-time employee or a terminated employee during the period during which no hours of service are credited.*" (Emphasis added). Treas. Reg. § 54.4980H-3(d)(6)(i).

Under a technical reading of the applicable rules (but a reading that is nevertheless consistent with our understanding of the individual views advanced by the regulators), service continues during an unpaid LOA for purposes of determining whether an employer must make an offer of coverage or extending a measurement period. Of course, an employer might be tempted to artificially limit unpaid LOAs to 13 weeks, but that may not be possible based on other laws such as the Americans with Disabilities Act.

The examples that follow illustrate the treatment of unpaid LOA under the look-back measurement method. In each case, assume that a terminated/rehired employee (Employee A): (i) is in a stability period that ends December 31, 2015, with respect to which A worked on average 30 or more hours per week during the corresponding measurement period (and therefore qualified for an offer of coverage during the stability period); (ii) goes out on an unpaid LOA (that is not special unpaid leave) on March 15, 2015; and (iii) later resumes service as of the date indicated:

- A is rehired May 15, 2015 (break is 61 days/8 weeks): A does not have a break-in-service for look-back measurement period purposes, since the period between the date services cease and the date on which they resume is less than 13 weeks. Coverage must be offered during the period the employee was on unpaid LOA in order to avoid penalties. In addition, A's employer must continue to use the same measurement period (with zero hours credited during the period from March 15 to May 15). But if A simply terminated employment on March 15, no coverage would have to be offered during the period that A was not employed.
- A is rehired August 10, 2015 (break is 148 days/21 weeks): A has a break-in-service for look-back measurement period purposes, since the period between the date services cease and the date on which they resume is greater than 13 weeks. Coverage must be offered during the period the employee was on unpaid LOA in order to avoid penalties, but coverage need not be offered when A resumes performing services on August 10. A's employer may apply a new initial measurement period (starting, e.g., August 10 or September 1) upon A's resumption of services.
- A is rehired December 15, 2015 (break is 275 days/39 weeks): A has a break-in-service for look-back measurement period purposes, since the period between the date services cease and the date on which they resume is greater than 13 weeks. Coverage must be offered during the period the employee was on unpaid LOA in order to avoid penalties, but coverage need not be offered when A resumes performing services on December 15. A's employer may instead apply a new initial measurement period (starting, e.g., December 15 or January 1, 2016) upon A's resumption of services.
- A is rehired January 15, 2016 (break is 306 days/43 weeks): A has a break-in-service for look-back measurement period purposes, since the period between the date services cease and the date on which they resume is greater than 13 weeks. Coverage must be offered during the balance of the stability period ending December 31, 2015 in order to avoid penalties. A's employer may apply a new initial measurement period (starting, e.g., January 15 or February 1, 2016) upon A's resumption of services.

These examples were originally prepared by Linda Mendel of Vorys, Sater, Seymour and Pease, LLP, and co-Chair of the Welfare Plan Issues, EEOC, FMLA, and Leave Issues Subcommittee of the Employee Benefits Committee of the American Bar Association. Special thanks to Linda for her gracious willingness to permit the use of her work for this post.

Tags: ACA, Affordable Care Act, IRS, monthly measurement method Section § 4980H; break-in-service; hours of service, special unpaid leave; look-back measurement method, unpaid leaves of absence

The Affordable Care Act—Countdown to Compliance for Employers, Week 13: IRS Notice 2014-49 Offers Useful Guidance on Changes in Measurement Periods or Changes in Testing Methods

Posted By Michael Arnold on September 29th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

For purposes of complying with the Affordable Care Act's employer shared responsibility rules (which are codified in Internal Revenue Code § 4980H), employers must identify their "full-time employees." Final regulations issued under Code § 4980H provide two principle testing methods for making this call: the "monthly measurement method" and the "look-back measurement method." (The final regulations are available here. See here for a useful IRS summary). In recently-issued Notice 2014-49, the Internal Revenue Service offers proposed approaches that employers may use when addressing changes in and among measurement methods, including:

- A change in the look-back measurement method (e.g., where an employee transfers within an employer from a position for which one measurement period applies to a position for which a different measurement period applies); or
- Where the measurement period applicable to an employee changes (e.g., an employer changes the measurement method applicable to employees within a permissible category).

Background

The Code § 4980H final regulations prescribe categories of employees within which an employer may apply a particular measurement period. The categories are (i) collectively bargained employees and non-collectively bargained employees, (ii) each group of collectively bargained employees covered by a separate bargaining agreement, (iii) salaried employees and hourly employees, and (iv) employees whose primary places of employment are in different states. With respect to each of the enumerated categories, an employer may use measurement and stability periods that differ either in length or in their starting and ending dates, or it may apply either the look-back measurement method or the monthly measurement method. But employers are not free, for example, to use the look-back measurement method for employees with variable work schedules and the monthly measurement method for employees with more predictable work schedules.

The final regulations include extensive and complex rules that apply to an employee who experiences a change in employment status from a position for which the look-back measurement method is used to a position for which the monthly measurement method is used (or vice versa). These rules generally require that an employee transferring from a position for which the employer is using the look-back measurement method to a position for which the employer is using the monthly measurement method (and who at the date of transfer is in a stability period during which the employee is treated as a full-time employee) must continue to be treated as a full-time employee during the remainder of the stability period. If the employee is in a stability period for which the employee is not treated as a full-time employee, the employer may continue to treat the employee as not a full-time employee during the remainder of the stability period. The rule extends to the stability period that immediately follows the stability period during which the employee transferred. The intent is to protect the transferring employee by giving him or her the better of the two methods during the handoff to the new measurement method. But the final regulations do not address whether, or under what conditions, an employer that uses a measurement method for a category of employees may subsequently change that measurement method. Instead, the preamble to the final regulations states, 79 Fed. Reg. 8563 (Feb. 12, 2014):

"The Treasury Department and the IRS anticipate that the rules with respect to a transfer from a position to which one look-back measurement method applies to a position to which another look-back measurement method applies will require complex rules because the methods may differ not only in the length of the applicable measurement and stability periods, but also the starting dates of the measurement periods. . . . To provide for these rules in the most comprehensible format, as well as to ensure flexibility to address situations that arise that have not currently been contemplated, the final regulations provide that with respect to the determination of full-time employee status, the Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin."

Notice 2014-49 makes good on that promise.

Notice 2014-49

Employee transferring from a position for which one measurement period applies to a position for which a different measurement period applies

This first of the two situations addressed in the notice involves instances in which an employee, who has been employed in one position (the "first position") for which the employer uses the look-back measurement method, transfers to another position (the "second position") for which the employer also uses the look-back measurement method, but with a measurement period that is different from the measurement period applicable to the first position. Under this proposed approach, following a transfer, an employer includes hours of service earned in the first position either by counting the hours of service using the counting method applied to the employee in the first position, or recalculating the hours of service earned in the first position using the hours of service counting method applied to the employee in the second position. The employer must in each case treat all similarly situated employees consistently.

The approach envisioned by the notice varies depending on whether the transferring employee is in a measurement, stability, or administrative period. (The notice reminds us that an initial measurement period does not apply to new employees who are full-time employees, and so are not variable-hour, seasonal, or part-time employees.)

(i) Employees in a stability period or an administrative period

If an employee is in a stability period or an administrative period applicable to the first position as of the date of transfer, the employee's status as a full-time or non-full-time employee for the first position remains in effect until the end of that stability period. At the end of the stability period, the employee assumes the full-time employee or non-full-time employee status that the employee would have under the look-back measurement method applicable to the second position, but including hours of service in the first position when applying that measurement method.

Example: Position 1 and Position 2 are two positions at the same applicable large employer. For Position 1, the employer uses 12-month standard measurement and stability periods beginning January 1. For Position 2, the employer uses 12-month standard measurement and stability periods beginning July 1. There are no administrative periods.

Employee A is an ongoing employee in Position 1 who during the 2015 standard measurement period averages less than 30 hours of service per week (so she is not offered coverage during the 2016 stability period). Employee A does, however, average 30 or more hours of service per week during the period from July 1, 2015 through June 30, 2016. On August 15, 2016, Employee A transfers to Position 2. For the period from August 15, 2016 through December 31, 2016 (the end of the stability period for Position 1 during which the transfer occurs), Employee A retains her status as a non-full-time employee.

As of January 1, 2017, Employee A's status is determined under the look-back measurement method applicable to Position 2. Employee A is a full-time employee starting January 1, 2017, because Employee A averaged 30 or more hours of service per week in the measurement period for Position 2 beginning July 1, 2015 and ending June 30, 2016 (which has a stability period of July 1, 2016 through June 30, 2017). After June 30, 2017, Employee A's status continues to be determined using the applicable measurement period for Position 2.

In sum, the rule requires an employer to run out the employee's status as full-time (or not) for the current Position 1 stability period, then shift to the Position 2 measurement and stability period taking into account all Position 1 hours of service.

(ii) If an employee is not in a stability period or in an administrative period immediately following the end of the initial measurement period, the employee's status as a full-time or non-full-time employee is determined solely under the look-back measurement method applicable to the second position as of the date of transfer, including all hours of service in the first position.

Example: For Position 1, the employer uses 12-month standard measurement and stability periods beginning January 1 and a 12-month initial measurement period beginning on each employee's start date. For Position 2, the employer uses 6-month standard measurement and stability periods beginning January 1 and July 1 and a 6-month initial measurement period beginning on an employee's start date. The employer hires Employee B into Position 1 as a new variable-hour employee on January 1, 2015. Employee B averages 30 or more hours of service per week during the period from January 1 through June 30, 2015. On October 1, 2015, at which time Employee B is in the initial measurement period for Position 1, Employee B transfers from Position 1 to Position 2.

At the date of the transfer, Employee B is not in a stability period for Position 1 because Employee B has not been employed for a full initial measurement period or a full standard measurement period. Accordingly, Employee B's status is determined under the measurement method applicable to Position 2 as of the date of transfer, taking into account Employee B's hours of service in Position 1.

Employer-initiated changes in measurement methods for one or more permissible categories of employees

The second of the two situations addressed in the notice involves instances in which an employer changes the measurement method applicable to a permissible category of employees. A change in measurement method may include a change from the look-back measurement method to the monthly measurement method (or vice versa), or a change in the duration or start date of any applicable measurement period under the look-back measurement method.

Generally, the status of any employee whose applicable measurement period under the look-back measurement method is changed by the employer is determined as if the employee had transferred from a position for which the original measurement method applies to a position for which the revised measurement method applies as of the effective date of the change, applying existing rules (described above) that govern changes in employment status from a position for which the look-back measurement method is used to a position for which the monthly measurement method is used or vice versa.

The notice provides an example in which an employer determines the full-time employee status of employees covered by a particular collective bargaining agreement (CBA) using 6-month measurement and stability periods, each starting April 1 and October 1, and determines the status of employees not covered by the CBA using 12-month measurement and stability periods, each starting January 1. On April 1, 2017, the employer changes the look-back measurement method for employees not covered by the CBA to be the same as that used for employees covered by the CBA. The example continues:

For a transition period following the date of this change, the status of employees not covered by the CBA must be made in a manner consistent with this notice, treating each employee who is subject to the measurement method applicable to employees not covered by the CBA as if on April 1, 2017, that employee had transferred from a position subject to the original measurement method to a position subject to the revised measurement method. Accordingly, each employee subject to the measurement method applicable to employees not covered by the CBA who is in a stability period as of April 1, 2017 retains his or her status as a full-time employee or non-full-time employee, as determined under the original measurement method for the remainder of the 12-month stability period applicable to that employee. Each such employee who is not in a stability period as of April 1, 2017 has his or her status determined as of April 1, 2017 in accordance with the 6-month measurement method.

Impact on mergers and acquisitions

The notice invites comments on "the potential application of the proposed approach described in this notice, or similar rules, in the context of a corporate transaction such as a merger or acquisition involving employers using different measurement methods." According to the notice, entities involved in corporate transactions may (and likely will) "have different measurement methods for their respective employees in a particular category." Until further guidance is issued (and at least through the end of calendar year 2016), the notice allows a party to a corporate transaction in which employers use different measurement methods "to rely on the approach described in the notice."

In addition, the notice provides transition relief under which a party to the transaction "will not be treated as applying an impermissible categorization of employees" merely because it continues to apply the measurement method in effect immediately before the corporate transaction. The transition period starts on the date of the transaction and ends on the last day of the first stability period following a standard measurement period that would have applied to the new employees and that begins after the date of the transaction (or, in the case of an employer that uses the monthly measurement method with respect to a category of employees, the last day of the first calendar year that begins after the date of the transaction).

Tags: ACA, Affordable Care Act, IRS, look-back measurement method, monthly measurement method, Notice 2014-49, Section 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 14: IRS Notice 2014-55 Gets the Employer Shared Responsibility Rules to Play Nice with the Rules Governing Mid-Year Cafeteria Plan Elections, Among Others

Posted By Michael Arnold on September 22nd, 2014 Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Treasury Department and the IRS had a busy week issuing no less than five Affordable Care Act guidance items, consisting of:

(i) Filer instructions for Form 8962 (Premium Tax Credit/Advanced Premium Tax Credit);

(ii) Filer instructions for Form 8965 (Exemptions);

(iii) a Notice on the Patient-Centered Outcomes Research Institute Fee;

(iv) a Notice on Additional Permitted Election Changes for Health Coverage under § 125 Cafeteria Plans; and

(v) a Notice on Shared Responsibility for Employers Regarding Health Coverage – Approach to Changes in Measurement Periods/Methods.

This post addresses item (iv), i.e., IRS Notice 2014-55 (relating to modifications to qualifying events for cafeteria plan relief). Next week's post will explain item (v) relating to employees changing status under the Employer Shared Responsibility rules implementing the look-back measurement method.

Background

With so much attention being paid to compliance with the Affordable Care Act's Employer Shared Responsibility rules, it is sometimes easy to forget that these are not the only rules that govern the maintenance and operation of employer-sponsored group health plans. In the case of mid-year cafeteria plan elections, however, the Act and prior law do not mesh well. In particular, the concept of a "stability" period (introduced by the final employer shared responsibility rules) contemplates that an employer might continue to offer coverage despite a reduction in hours. This is something of a novel concept. Moreover, that employees have a new coverage option from public health exchanges was not a possibility when final regulations governing mid-year election changes under cafeteria plans were promulgated.

Cafeteria plan rules

Cafeteria plans are generally required to provide that elections are irrevocable during a period of coverage (i.e., the plan year) except in certain optional instances involving changes in an employee's status or changes in cost or coverage. A cafeteria plan may allow an employee to revoke an election during a period of coverage and make a new election for the remaining portion of the period, if—

- A change in status (including a change in employment status) occurs, and

- The election change satisfies certain consistency requirements.

A change in employment status is limited to a change in an individual's employment status that results in a change in the individual's eligibility for coverage under the group health plan. So a change in employment status that does not result in an employee either becoming or ceasing to be eligible for coverage under the group health plan, as is the case during a stability period, is not a change in status for which a plan may allow the employee to revoke an election.

The consistency rules are satisfied only if the individual enrolls in the coverage for which the individual is newly eligible. That is, an individual gaining eligibility for coverage under a group health plan cannot use that change in status to revoke coverage entirely.

The employer shared responsibility rules

The Act's employer shared responsibility rules subject applicable large employers to assessable payments if an employer fails to offer minimum essential coverage to its full-time employees and one or more full-time employees qualifies for a premium tax subsidy from a public exchange. An employer may use the look-back measurement method to determine the status of an employee as full-time or not full-time. Under the look-back measurement method, an employee determined to be full-time based on hours of service during a measurement period must be treated as a full-time employee during a subsequent stability period, regardless of the employee's hours of service during the stability period. Accordingly, under the look-back measurement method, an employee could have a change in employment status (for example, a change from a full-time position to a part-time position) resulting in a reduction in hours that does not change the employee's status as a full-time employee. Where the look-back measurement method is applied, the change in employment status during a stability period does not result in a change in an employee's eligibility for the group health plan. Thus, the change in employment status in this instance would not allow the employee to change the employee's election under the cafeteria plan during the period of coverage.

Interaction with enrollment in a Qualified Health Plan

Under the current rules governing cafeteria plan mid-year election changes, a cafeteria plan may not allow an employee to revoke an election under the group health plan during a period of coverage solely to enroll in a Qualified Health Plan through a Marketplace. Thus, an individual enrolled through a cafeteria plan in a group health plan with a non-calendar plan year might not be able to synchronize the change in coverage to avoid an overlapping period of coverage or a period without coverage because the open enrollment period rules for public exchange Marketplaces don't permit the purchase of coverage beginning at the end of the non-calendar cafeteria plan year other than where an individual has special enrollment rights (birth, marriage, or adoption of a child).

Notice 2014-55

Notice 2014-55 addresses two specific situations in which a cafeteria plan participant may wish to revoke coverage mid-year.

- Revocation due to reduction in hours of service. The first situation involves a participating employee whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under the employer's group health plan.
- Revocation due to enrollment in a Qualified Health Plan. The second situation involves an employee participating in an employer's group health plan who would like to cease coverage under the group health plan and purchase coverage through a public exchange either in a period of duplicate coverage under the employer's group health plan and the coverage purchased through a Marketplace or in a period of no coverage.

Revocation due to reduction in hours of service

A mid-year election change based on reduction in hours of service requires that:

1. The employee was reasonably expected to average at least 30 hours of service per week and there is a change in that employee's status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the group health plan; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Importantly, due to the consistency requirement that applies to mid-year cafeteria plan election changes, an employee in a stability period who reduces hours may not drop coverage altogether. Instead, he or she must get coverage elsewhere—i.e., either through a public exchange, coverage under a spouse's plan, or some other source.

The notice permits the plan to rely on the "reasonable representation" of the employee that he or she has enrolled or intends to enroll in other coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Revocation due to enrollment in a Qualified Health Plan

A mid-year election change based on enrollment in a Qualified Health Plan requires that:

1. The employee is eligible for a special enrollment period to enroll in a Qualified Health Plan, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in a Qualified Health Plan through a public exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The notice permits the plan to rely on the "reasonable representation" of the employee that he or she (and related individuals) have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Conclusion

While there are certainly much more high profile questions that employers face as they work toward complying with the Affordable Care Act, Notice 2014-55 is nevertheless welcome guidance. The notice provides clear, and (it seems to us) workable, rules that will enable employers to coordinate cafeteria plan elections with the look-back measurement method. The guidance also comes well in advance of the time that it will be needed. The changes made by Notice 2014-55 will of course require cafeteria plan amendments, which means that there is at least one more item for the compliance checklist.

Tags: ACA, Affordable Care Act, § 125 Cafeteria Plans, Employer Shared Responsibility rule, Form 8962, Form 8965, IRS, look-back measurement method, Notice 2014-55, qualified health plan

The Affordable Care Act—Countdown to Compliance for Employers, Week 15: Can a Plan That Fails to Cover Inpatient Hospitalization Services Provide Minimum Value?

Posted By Michael Arnold on September 16th, 2014 Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

A recent *Washington Post* article ("Glitch in health care law allows employers to offer substandard insurance," September 12, 2014) highlights an Affordable Care Act compliance strategy being marketed heavily (and adopted widely) in industries that traditionally did not previously offer coverage to large cohorts of variable hour and contingent workers. (We discussed these arrangements in a previous post. The strategy—which is referred to commercially as a "minimum value plan" or "MVP"— involves an offer of group health plan coverage that, while similar in most respects to traditional major medical coverage, carves out inpatient hospital services.

The *Washington Post* article (and other commentary) engages in some hand-wringing about why these plans are inconsistent with the goals of the Act. One commentator fumed that an employer that offers these arrangements should "examine its conscience." (Readers might recall a similar bout of hand-wringing that accompanied "skinny" plans.)

It's time to take breath.

Whether these plans were "intended," or whether they are consistent with Obamacare, is irrelevant. Under currently applicable laws and regulations, these plans appear to work as advertised. Moreover, no employer is required to do anything more than the law requires; and any employer that does risks putting itself at a competitive disadvantage relative to those that do not. The regulators are free to change the rules. Despite a high likelihood that they are aware of these plans, however, they have not yet seen fit to act.

MVP arrangements are generally offered in a suite of products and accompanying administrative services that include:

- A "Minimum Essential Coverage" or "MEC" plan (previously known as a "skinny plan")

These plans qualify as an offer-of-coverage for purposes of the more severe of the two levels of penalties, i.e., the penalty for failing to make an offer of coverage to substantially all full-time employees.

- A "hospital or fixed indemnity plan"

A hospital or fixed indemnity plan is a type of plan that pays fixed amounts for specific medical services and care. These plans are structured as "excepted benefits" that are not subject to the Affordable Care Act's insurance market reforms and other requirements when offered on a non-coordinated basis. That is, employees must be free to elect or reject this coverage independent of any other coverage they might elect or reject.

- An MVP arrangement

An MVP arrangement is a major medical plan that carves out inpatient hospital services. The goal is to reduce the aggregate premium cost of minimum value coverage so that the cost of providing coverage that is "affordable" is similarly lowered. For example, the premium cost of a traditional major medial plan offered on a fully-insured basis by a top-tier,

national carrier might be, say, $500 or more. But for an MVP arrangement the cost might be $200. (MVP arrangements are generally if not universally self-funded.)

Background

To understand the benefits of an MVP arrangement requires an understanding of "minimum value." Group health plan coverage is deemed to provide minimum value if the "percentage of the total allowed costs of benefits provided under a group health plan" is at least 60% of all plan benefits, without regard to co-pays, deductibles, co-insurance, and employee premium contributions. Under a final rule issued by the Department of Health and Human Services (HHS), the "percentage of the total allowed costs of benefits provided under a group health plan" is defined as—

- The anticipated covered medical spending for essential health benefits (EHB) coverage paid by a health plan for a standard population,
- Computed in accordance with the plan's cost-sharing, and
- Divided by the total anticipated allowed charges for EHB coverage provided to a standard population.

EHB includes a list of 10 categories of coverage that individual and small group plans must cover. While self-funded groups and large fully insured groups are not required to cover all EHBs, whether they provide minimum value is determined by comparing the benefits provided to a benchmark set of EHBs. Among other methods, HHS permits employers to determine minimum value using an on-line calculator. Employers can input a set of standard plan design parameters, for which the calculator will return a value. If the value is 60% or greater, the plan is deemed to provide minimum value.

The MVP conundrum

The MVP strategy is shockingly simple: remove the high cost items from the plan (i.e., inpatient hospital services) from the plan while being more generous with other EHB components and by adopting generous cost-sharing features. This leads to two interrelated, but separate, questions:

(1) Is it even possible for a plan to get to 60% minimum value without covering inpatient hospital services?

We don't know for certain—even reasonable actuaries seem to disagree. For a dissenting view, see an article by Hobson D. Carroll, FSA, President, MedRisk Actuarial Services, Inc., entitled, "A Dangerous Game—Testing the Limits of the MV Calculator as Sole Determiner of Minimum Value," published August 13, 2014.

(2) For purposes of calculating assessable payments under the Act employer shared responsibility rules, can an MVP arrangement be deemed to provide minimum value?

Here the answer appears to be, yes.

The matter of what services a plan might need to cover was examined in a November 2011 report entitled, "Actuarial Value and Employer-Sponsored Insurance," ASPE Research Brief, U.S. Department of Health and Human Services. The report concluded that four core categories of benefits and services are the greatest contributors to a health plan's actuarial value: physician and mid-level practitioner care; hospital and emergency room services; pharmacy benefits; and laboratory and imaging services. Because they account for only a very small portion of overall medical expenditures, benefits and services beyond these four core categories of benefits that are covered by a plan generally have only a limited impact on the plan's actuarial value.

The HHS report was cited with approval in a notice published in 2012 (Notice 2012-31) in which the Treasury Department and IRS anticipated that getting to 60% minimum value would require coverage of all four major categories. When discussing the anticipated use of an online calculator as one means of determining a plan's minimum value, here's what they said:

"[The] calculator generally would be used to make minimum value determinations by employer-sponsored plans that have standard cost-sharing features. An employer-sponsored plan would be able to input a limited set of information on the benefits offered under the plan and specified cost-sharing features (for example, deductibles, co-insurance, and maximum out-of-pocket costs) for the four core categories of benefits: physician and mid-level practitioner care, hospital and

emergency room services, pharmacy benefits, and laboratory and imaging services. The calculator would also take into consideration the annual employer contributions to an HSA or amounts made available under an HRA, if applicable."

But this is not what happened (at least so far). A subsequent proposed regulation (Proposed Treasury Regulation § 1.36B-6(c)(1)) does not impose a requirement that a plan must cover all four categories in order to reach minimum value. The preamble to that proposed regulation instead explained that:

"The proposed regulations *do not require employer-sponsored self-insured and insured large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to qualified health plans.* The preamble to the HHS regulations (see 78 FR 12833) notes that employer-sponsored group health plans are not required to offer EHBs unless they are health plans offered in the small group market subject to section 2707(a) of the Public Health Service Act." (Emphasis added.)

The regulation provides:

(c) MV percentage—(1) In general. An eligible employer-sponsored plan's MV percentage is—

(i) The plan's anticipated covered medical spending for benefits provided under a particular essential health benefits (EHB) benchmark plan described in 45 CFR 156.110 (EHB coverage) for the MV standard population based on the plan's cost-sharing provisions;

(ii) Divided by the total anticipated allowed charges for EHB coverage provided to the MV standard population; and

(iii) Expressed as a percentage.

Admittedly clause (i) is not intuitively obvious. But any doubt about its import is dispelled by looking to the CMS document that explains the MV calculator methodology. Here is what CMS has to say (page 6):

"Because large employer plans are not required to cover the essential health benefits (EHB), the MV Calculator allows the user to indicate that a service listed in the calculator is not covered. In order to account for the shift in the total per member per year (PMPY) average spending distribution when removing carved-out services, the following adjustment is performed. First, the proportion of average spending that the carved out services account for is calculated for every point in the continuance tables. This proportion is then multiplied by the ratio between the total spending level and average per member per year spending for enrollees capped at that spending level, and then subtracted from the total spending level. This creates a new continuance distribution with modified total spending but unmodified utilization rates. The MV calculation proceeds regularly, with carved-out services subject to the deductible, 0% coinsurance, and their MOOP [(maximum out-of-pocket)] removed from the numerator but not from the denominator of the MV calculation."

Thus, the numerator begins with all of the EHBs in a particular benchmark plan, but then backs out those items that the plan does not cover. (In the case of an MVP arrangement, that includes inpatient hospital services.)

The role of Department of Health and Human Services (HHS) and the Treasury Department/IRS in MV determinations requires some explaining. The provisions of the Internal Revenue Code dealing with premium tax credits include what has been referred to as a "firewall" under which an individual who is otherwise eligible for a premium tax credit is rendered ineligible if he or she is offered coverage under an eligible employer-sponsored plan (which would include an MVP arrangement) if that coverage is affordable and provides minimum value. But the Act delegates to HHS the job of establishing rules governing MV. Thus, one needs to look to HHS rules for this purpose, for which there is a final rule. According to 45 CFR 156.145(a) employers may use one of four methodologies to determine MV:

- The MV Calculator made available by HHS and the Internal Revenue Service (IRS). If a group health plan offers benefits outside of the MV calculator, the plan may seek an actuary to determine the value of those benefits and adjust the MV calculator results accordingly;
- Any safe harbor established by HHS and the Internal Revenue Service;
- A group health plan may seek certification by an actuary to determine MV if the plan contains non-standard features that are not suitable for either of the above methods; or
- Any plan in the small group market that satisfies any of the metal tiers (platinum, gold, silver, and bronze) is deemed to provide minimum value.

MVP arrangements are designed to avoid non-standard features. They get to minimum value with the inputs on the face of the calculator. Thus, for an MVP arrangement, MV is what HHS says it is, and HHS says that MV is what the calculator says it is.

What's next?

As the title of the *Washington Post* article referenced above demonstrates, the "blame" for MVP arrangements is being placed on faults under the hood of the calculator. But to date, we have not encountered any rigorous demonstration making the case for that claim. Moreover, even a cursory reading of the HHS document explaining the calculator methodology leads to the conclusion that a great deal of time, thought, effort and expertise was expended in the process of building the calculator. So it may be that the calculator works as it was intended.

But it does not matter. At present, MV is what the calculator says it is. The regulators are free to change that. Given that many MVP arrangements have already been contracted for, and many other are near being signed, one would hope from a purely practical perspective that these arrangements are permitted to go forward at least for 2015. And, yes, the coverage under an MVP arrangement is less than desirable. As such, employers will need to be particularly attentive to the way that they communicate the terms to employees. Any failure to call prominent attention to the lack of inpatient hospital services will almost certainly result in participant claims under ERISA and perhaps other Federal and state laws.

Tags: ACA, Affordable Care Act, CMS, EHB, ERISA, essential health benefits, Excepted Benefits, fixed indemnity plan, HHS, Hobson D. Carroll, HRA, HSA, IRS, MEC, minimum essential coverage, minimum value, minimum value plan, MOOP, MV Calculator, MV Percentage, MVP, PMPY, Public Health Service Act, skinny plan, Treasury Department, Washington Post

The Affordable Care Act—Countdown to Compliance for Employers, Week 16: So What, Exactly, is an "Offer of Coverage"?

Posted By Michael Arnold on September 8th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written By Alden J. Bianchi and Edward A. Lenz

Whether an employer makes the requisite offer of group health plan coverage is critical to the application of the Affordable Care Act's employer shared responsibility rules as reflected in final implementing regulations issued earlier this year (and see here for a useful IRS summary of those rules). The rules are codified in a newly added provision of the Internal Revenue Code, i.e., Code § 4980H. Generally, Code § 4980H imposes penalties or "assessable payments" where "at least one full-time employee" qualifies for subsidized coverage from a public exchange, and either:

- An "applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan . . . for any month," or
- "An applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan . . ." but that coverage is either unaffordable or fails to provide minimum value.

There is no shortage of commentary on the particulars of the Code § 4980H assessable payments. Surprisingly little attention has been paid however—either by the regulators or the commentators—to what, exactly, it means to make an offer of coverage.

In at least one instance, the Treasury Department and IRS let us know what an offer of coverage is not, when they clarified that an employer cannot foreclose the possibility of all penalties by providing coverage to all its full-time employees at no cost. (Their views are set out in the preamble to a May 3, 2013 proposed regulation dealing with minimum value.

As we have noted on many occasions, the challenges of complying with the employer shared responsibility rules affects employers differently depending on industry and workforce demographics. For employers with large stable workforces to whom robust major medical benefits are widely offered, these rules will have all the challenges of a speed bump. These employers have been making offers of coverage in many cases for decades, and their compliance with applicable law, while rarely perfect, is generally good or at least good enough. But for employers with high turnover and large cohorts of contingent and temporary workers, these rules are game-changing. And offers of coverage, at least to sometimes significant portions of their workforce, are new.

There is likely a good reason why the particulars of what constitutes an offer of coverage has attracted little attention. While compliance with the ACA's employer shared responsibility rules is tested based on whether an offer of coverage is made, other Federal laws (principally ERISA) speak to what it means to make such an offer. In a recently published set of questions and answers, we have endeavored to shed some light on the topic. While these Q&As nominally address the staffing industry, their application is far more universal. They include (at least as we see it) three important takeaways:

- While not required, it may well fast become a best practice to obtain written waivers from employees who turn down an employer's offer of group health plan coverage. This issue arose early on in the implementation of the 2006 Massachusetts health care reform law. Despite less than solid statutory support, the regulators imposed this requirement on audit, much to the dismay and annoyance of the audit targets.

- Compliance with the ERISA plan document and summary plan requirements has historically been—to be kind—"spotty." The ACA has raised the bar here. Employers would be well advised to pay attention. The ERISA "wrap document" will in all likelihood become the de facto standard. (This despite that, in the view of some, recent judicial authority has cast some doubt on the practice of combining the plan document and the summary plan description by making liberal use of incorporation by reference.)
- Additional and very explicit disclosures are a very good idea in cases where employers seek to use novel or aggressive plan designs. (See our August 18 post for a description of the sorts of designs we have in mind.) While these arrangements may work like a charm for an employer trying to limit its exposure under Code § 4980H, the consequence to employees for failing to understand the terms of the coverage they have enrolled in can be—to be kind—suboptimal.

Tags: ACA, Affordable Care Act, assessable payments, ERISA, IRS, offer of coverage, Section 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 17: Cherry Bomb in the Gold Fish Pond, or Third-Party Staffing Arrangements and "Offers of Coverage by Unrelated Employers"

Posted By Michael Arnold on September 3rd, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

By Alden J. Bianchi and Edward A. Lenz

With two seemingly simple and straightforward definitions in the final regulations implementing the Affordable Care Act's pay-or-play rules—i.e., definitions of "employer" and "employee"— the Treasury Department and IRS have raised a host of concerns for third party staffing arrangements. (The IRS has provided a useful summary of the final regulations in a set of Questions and Answers.) Both definitions adopt the "common law" standard. In so doing, there is no evidence that the regulators intended to change prior law. But unwittingly or otherwise, the preamble to the final regulations provides ample evidence that the industry's view of these terms is at odds with that of the regulators.

For decades, the mainstream staffing industry, with ample legal precedent, has considered the workers that staffing firms place with their clients as common law employees of the staffing firm, and not the client. This is in marked contrast to Professional Employer Organizations (or "PEOs") that, at least since 2002, have generally, though not universally, considered their external workers to be the common law employees of the client. Treasury and IRS guidance in the matter is generally sparse, as is judicial authority. This is understandable since staffing firms and PEOs generally treat their external workers as employees and not independent contractors. The question was not, "is this worker an employee or an independent contractor," it was, instead, "whether the worker is the common law employee of the staffing firm or the client organization." Thus, *someone* is issuing a Form W-2 to the workers, so misclassification generally did no harm to the U.S. Treasury. Code § 4980H complicates this calculus.

Both the preamble to the final regulations and the regulations themselves recognize that three-party employment arrangements pose unique issues. In a handful of instances, the regulations endeavor to provide accommodations and special rules. For example, when determining a newly hired employee's status as "variable hour," the final regulations provide additional factors to be considered in the case of employees "hired by an employer for temporary placement at an unrelated entity"— factors specifically designed to apply to temporary staffing firms who are common law employers.

The final regulations also recognize that in some third-party staffing arrangements, the staffing firm, and not the client organization, will make the offer of group health plan coverage that is intended to satisfy the pay-or-play rules. The regulations permit an offer of coverage by an unrelated employer in cases where the employee to whom coverage is offered by the staffing firm is the common law employee of the client. This rule could be used either intentionally, e.g., by a PEO that offers group health plan coverage, or prophylactically, e.g., contractually, as an audit safe harbor. In either case, the staffing firm or PEO must charge an additional fee with respect to employees that actually accept coverage. The purpose of the fee is to treat the coverage as being paid for in whole or in part by the client organization.

To understand what is at stake, consider the following example:

Employer X has 300 full-time employees, 100 of whom are retained through Staffing Firm Y. Employer X makes an offer of minimum essential coverage to its remaining 200 full-time employees under an eligible employer sponsored plan maintained by Employer X. Under the terms of the staffing agreement, Staffing Firm Y must make an offer of minimum essential coverage to any full-time employee who it places with Employer X under an eligible employer sponsored plan

maintained by Staffing Firm Y. If the employees placed through Staffing Firm Y are the common law employees of Employer X and not of Staffing Firm Y, then, in the absence of the rule governing offers of coverage on behalf of another entity, Employer X would owe an assessable payment under Code §4980H(a), since it would have made an offer of coverage to only 66% of its full-time employees. But if the conditions of the special rule governing offers of coverage on behalf of another entity are satisfied, then Employer X would be deemed to have made an offer of coverage to 100% of its full-time employees, thereby escaping exposure under Code §4980H(a).

As a consequence of the rule recognizing offers of coverage by unrelated employers, third-party employment arrangements have a way to navigate the Act's employer shared responsibility rules. That's the good news. The bad news is that there are other laws—Federal and state—that the final regulations do not address. These include the following:

- MEWA status of the staffing firm's group health plan

If employees placed with a client organization are the common law employees of the client organization but are covered under the staffing firm's group health plan, then that plan is, and is regulated as, a multiple employer welfare arrangement. If the plan is fully insured, then it may violate the terms of the agreement with the carrier that is under the impression that it is insuring a single-employer plan. In addition, if the client organization is a small group, the plan may run afoul of the state's small group requirements. The arrangement must also file annually a Form M-1 with the Department of Labor. And if the plan is self-funded, then the arrangement would likely constitute an unlicensed insurance company for state law purposes, or, in the alternative, fail to satisfy any separate state law governing self-funded MEWAs.

- Loss of tax deduction/exclusion under Code §105, §106, and §125

Amounts paid or reimbursed under a group health plan to or on behalf of employees and their dependents are deductible from an employee's gross income under Code §105, and pursuant to Code §106 an employee's gross income does not include the value of group health plan coverage. Similarly, group health plan contributions made by participants are excluded from gross income if made under a properly structured cafeteria plan that satisfies the requirements of Code §125. The term "cafeteria plan" means a written plan under which "all participants are employees." Where a group health plan covers individuals who are not common law employees of the staffing firm, then the Code §105 deduction and the §106 exclusion are unavailable. While the final Code §4980H regulations do not address these issues explicitly, the additional fee requirement appears to be intended to treat the plan as offered or paid for by the client, thereby preserving these deductions and exclusions.

- Impact on other benefit plans and programs

A determination that the employees being placed with a client organization are employees of the client affects other benefit programs. For example, if a staffing firm offers a 401(k) plan that covers the employees placed with a client organization, the plan would have to be structured as a multiple employer plan. This would require, among other things, separate testing of the employees assigned to the client.

For an in-depth discussion of these and other issues arising under the rules governing offers of coverage to unrelated employers, including the historical treatment of staffing firms as common law employers, please see our article entitled *The Final Code §4980H Regulations; Common Law Employees; and Offers of Coverage by Unrelated Employers*, to be published in the September 8, 2014 issue of the Bloomberg/BNA Tax Management Memorandum.

Tags: ACA, Affordable Care Act, cafeteria plan, common law employee, Department of Labor, Form M-1, IRS, PEO, Professional Employer Organization, Section § 4980H, staffing firm

The Affordable Care Act—Countdown to Compliance for Employers, Week 18: Emerging Strategies to Reduce or Eliminate Exposure for Assessable Payments under the Affordable Care Act's Pay-or-Play Rules

Posted By Michael Arnold on August 25th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Affordable Care Act's employer shared responsibility, or "pay-or-play," rules require "applicable large employers" (generally employers with 50 or more full-time and full-time equivalent employees) to offer group health plan coverage (i.e., "play") or face the prospect of having to pay money to the government (i.e., "pay"). These provisions are included in a new section of the Internal Revenue Code, Code § 4980H, as implemented by final regulations issued earlier this year, and the IRS has provided a useful summary of the rules in a set of Questions and Answers.

The impact of the Act's employer shared responsibility rules varies widely from employer-to-employer. Employers with stable workforces to whom they have traditionally provided broad-based, robust, major medical coverage—e.g., banking, finance, and information technology—will have little difficulty satisfying the Act's pay-or-play rules. In contrast, employers with large cohorts of variable and contingent workers to whom robust coverage was not previously offered will find these rules daunting. Examples of affected industries and sectors include staffing, restaurants, retail, franchise, and hospitality. It is this latter group of employers that is scrambling to find solutions that enable them to limit their exposure to penalties (or in the parlance of Code § 4980H, "assessable payments"). "Solutions" for this purpose means, simply, inexpensive group health plan coverage. And there is some urgency since the Act's pay-or-play requirements take effect January 1, 2015 (or 2016 for certain employers with between 50 and 100 full-time and full-time equivalent employees).

I. Background

The mechanics of the pay-or-play rules are by now generally familiar to affected employers and their advisors. The following explanation is provided for convenience. Readers already familiar with the rules are encouraged to skip to the next section – Managing Code § 4980H Liability.

Each applicable large employer is subject to an assessable payment if any full-time employee is certified as eligible to receive a low-income premium tax credit or cost-sharing reduction from a public insurance exchange and either:

- *Code § 4980H(a) Liability*

The employer fails to offer to all its "full-time employees" (and their dependents) the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan." Under this prong, if an employer fails to make an offer of coverage to its full-time employees, an assessable payment is imposed monthly in an amount equal to $166.67 multiplied by the number of the employer's full-time employees, excluding the first 30.

- or -

- *Code § 4980H(b) Liability*

The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that, with respect to a full-time employee who qualifies for a premium tax credit or cost-sharing reduction, either is (i) "unaffordable" or (ii) does not provide "minimum value." If the employer makes the requisite offer of coverage, the assessable payment is equal to $250 per month multiplied by the number of full-time employees who qualify for and receive a premium tax credit or cost-sharing reduction from a health insurance exchange. The amount of the Code § 4980H(b) Liability is capped at the Code § 4980H(a) Liability amount. As a result, an employer that offers group health plan coverage can never be subject to a larger assessable payment than that imposed on a similarly situated employer that does not offer group health plan coverage.

"Minimum essential coverage" includes coverage under an "eligible employer-sponsored plan." An "eligible employer-sponsored plan" includes "group health plans offered in the small or large group market within a state" but does not include "excepted benefits" as defined and described under the Public Health Service Act, e.g., stand-alone vision or dental benefits, most medical flexible spending accounts, hospital indemnity plans, etc.

Employer-provided health insurance coverage is deemed "unaffordable" if the premium required to be paid by the employee for self-only coverage exceeds 9.5% of the employee's household income. Final regulations issued under Code § 4980H offer three safe harbors—W-2, rate-of-pay, and Federal Poverty Limit—under which affordability may be determined.

Coverage is deemed to provide "minimum value" if it pays for at least 60% of all plan benefits, without regard to co-pays, deductibles, co-insurance, and employee premium contributions. Final regulations establish rules for determining minimum value which include the use of an on-line calculator.

If an employee accepts an employer's offer of coverage, despite that it is unaffordable or that it fails to provide minimum value, he or she has minimum essential coverage. As a consequence, he or she cannot qualify for a premium subsidy, even if he or she otherwise satisfies the applicable income requirements. Nor can the employer be subject to an assessable payment with respect to the employee.

II. Managing Code § 4980H Liability

A. Code § 4980H(a) Liability

The least expensive way to eliminate exposure for assessable payments under Code § 4980H(a) is to use a "minimum essential coverage" or "MEC" plan. (These plans are also referred to alternatively as "skinny" or "sub-minimum value" plans, and for a description of these plans, including their evolution, please see our prior posts here and here.) Because MEC plans address only the penalty under Code § 4980H(a), they are better suited to employers with relatively smaller numbers of low- and moderate income employees. These employees are eligible for subsidized coverage from a public insurance exchange, which means they are in a position to cause the employer to incur penalties under Code § 4980H(b).

An employer cannot foreclose the possibility of penalties by providing MEC plan coverage to all its full-time employees at no cost. The regulators anticipated this strategy in the preamble to a May 3, 2013 proposed regulation dealing with minimum value. Here's what they had to say (78 Fed. Reg. 25,909):

"Any arrangement under which employees are required, as a condition of employment or otherwise, to be enrolled in an employer-sponsored plan that does not provide minimum value or is unaffordable, and that does not give the employees an effective opportunity to terminate or decline the coverage, raises a variety of issues. Proposed regulations under section 4980H indicate that if an employer maintains such an arrangement it would not be treated as having made an offer of coverage. As a result, an applicable large employer could be subject to an assessable payment under that section. See Proposed § 54.4980H–4(b), 78 FR 250 (January 2, 2013). Such an arrangement would also raise additional concerns. For example, it is questionable whether the law permits interference with an individual's ability to apply for a section 36B premium tax credit by seeking to involuntarily impose coverage that does not provide minimum value. (See, for example, the Fair Labor Standards Act, as amended by section 1558 of the Affordable Care Act, 29 U.S.C. 218c(a).) If an employer sought to involuntarily impose on its employees coverage that did not provide minimum value or was unaffordable, the IRS and Treasury, as well as other relevant departments, may treat such arrangements as impermissible interference with an employee's ability to access premium tax credits, as contemplated by the Affordable Care Act." (Emphasis added).

B. Code §§ 4980H(a) and (b) Liability

In order to eliminate exposure to both the Code § 4980H(a) and Code § 4980H(b) penalties, the employer must offer coverage that is both affordable and provides minimum value. As a result, the aggregate cost of the premium for self-only coverage is an important variable: The lower the aggregate cost; the lower the cost to the employer of providing affordable coverage. One obvious approach for employers that did not previously offer coverage to all or most of their full-time employees is to simply extend the offer of coverage under their existing, major medical insurance plan. But that strategy has proved to be expensive in instances where the take up rate of the newly eligible employees is expected to be low, e.g., restaurants and staffing firms. While the Act imposes some new limits on a carrier's ability to impose minimum participation and contribution requirements, carriers are not constrained from increasing the price of coverage, or varying the price based on the take-up rate. As a result, the aggregate premium cost of self-only coverage has risen significantly in many instances.

III. Alternative, Emerging Strategies

With the extension of coverage under an employer's existing, major medical insurance plan off the table, there have evolved a handful of alternative strategies, many of which are self-funded, which seek to drive down the top-line, aggregate premium cost of group health coverage. These strategies include the following:

A. Reference pricing models

In a "reference pricing model" an employer or insurer establishes a maximum payment it will make for a specific service, e.g. knee surgery. We explained the reference pricing model in a previous post. The downside of reference pricing is, of course, that providers may be unwilling to accept the coverage, or the covered employee or his or her dependent might be liable for the balance in states where balance billing is permitted.

In a recent set of Frequently Asked Questions, the Department of Labor (joined by HHS and the Treasury Department) gave voice to concerns over reference pricing in connection with the Act's rules imposing caps on maximum out-of-pocket limits, saying:

"Reference pricing aims to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs. At the same time, the Departments are concerned that such a pricing structure may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers."

The Department of Labor invited "comment on the application of the out-of-pocket limitation to the use of reference-based pricing."

B. Major medical plans without inpatient hospital coverage

Coverage is deemed to provide minimum value if the "percentage of the total allowed costs of benefits provided under a group health plan" is at least 60% of all plan benefits, without regard to co-pays, deductibles, co-insurance, and employee premium contributions. Under a final rule issued by the Department of Health and Human Services (HHS), the "percentage of the total allowed costs of benefits provided under a group health plan" is defined as—

1. The anticipated covered medical spending for essential health benefits (EHB) coverage … paid by a health plan for a standard population,
2. Computed in accordance with the plan's cost-sharing, and
3. Divided by the total anticipated allowed charges for EHB coverage provided to a standard population.

EHB includes a list of 10 categories of coverage that individual and small group plans must cover. While self-funded groups and large fully insured groups are not required to cover all EHBs, whether they provide minimum value is determined by comparing the benefit provided to a benchmark set of EHBs. (For a detailed, though slightly dated, explanation of how these rules work, please see our previous post on this issue).

Among other methods, HHS permits employers to determine minimum value using an on-line calculator. Employers can input a set of standard plan design parameters, for which the calculator will return a value. If the value is 60% or greater, the plan is deemed to provide minimum value.

Certain plans offered on a self-funded basis have been able to remove inpatient hospital services from coverage and still get to a calculator-determined value of greater than 60%. This design results in an aggregate premium cost of less than half of that charged for traditional, major medical coverage. But the approach has others scratching their heads. In an earlier notice (Notice 2012-31), the Treasury Department and the IRS proposed that, for an employer-sponsored plan to provide minimum value, it would be required to cover four core categories of benefits: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services. This requirement was not carried over into the final rule, which instead relied on a comparison to EHB benchmarks. So, for now at least, these arrangements do appear to provide minimum value.

While there is every reason to believe that the regulators are fully aware of these plans, there is no indication as of the date of this post that they consider them abusive or otherwise see a problem. This could change, of course.

NOTE: There is a variant of this design that seeks to replace inpatient hospital services with a hospital indemnity feature that would pay a set dollar amount per day of inpatient hospitalization. Hospital indemnity arrangements are generally "excepted benefits" that are not subject to the Act. But this is true only when the benefit is not coordinated with other major medical coverage. So it's hard to see how such a feature would not run afoul of the bar on annual limits, for example.

C. Limited network arrangements

While the reference pricing models and the plans that dispense with inpatient hospital services are generally self-funded plans, this last approach is usually offered on a fully-insured basis. As the title implies, these plans are in most ways indistinguishable from any other major medical plan, except the covered individuals are restricted to a narrow set of in-patient providers.

Tags: ACA. Affordable Care Act, applicable large employers, eligible employer-sponsored plan, IRS, MEC, minimum essential coverage, pay-or-play, reference pricing model, Section § 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 19: Changes in Employment Status under the Look-Back Measurement Method

Posted By Michael Arnold on August 18th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

An earlier post explained the two principle methods—the "monthly measurement method" and the "look-back measurement method"—available to applicable large employers to identify full-time employees for purposes of determining exposure for "assessable payments" under the Affordable Care Act's employer shared responsibility rules. (Final regulations implementing rules are available at here.) This post focuses on how the look-back measurement method handles changes in employment status. While these rules appear simple and straightforward, this is not always the case in practice.

Background

Under the look-back measurement method, an employer determines the status of an employee as a full-time employee during a future period (referred to as the "stability period"), based upon the hours of service of the employee in a prior period (referred to as the "measurement period"). The final regulations prescribe two sets of measurement periods, an "initial measurement period," which generally begins on date-of-hire or the first day of the month following date-of-hire, and a "standard measurement period," which is a fixed period of at least three but not more than twelve consecutive months (e.g., the calendar year) selected by the employer. Each measurement period is followed by a corresponding "stability period," which is a period selected by the employer that immediately follows, and is associated with, a standard measurement period or an initial measurement period. While an employer is generally permitted to interpose an administrative period of up to three months between the measurement and stability periods, the combination of the initial measurement period plus the associated administrative period cannot exceed thirteen-and-fraction months.

As we explained in our prior post, when applying the look-back measurement method, a newly hired employee must be classified as full-time, variable hour, seasonal, or part-time. Once the newly hired employee has been employed for a full standard measurement period, however, he or she is no longer full-time, variable hour, seasonal, or part-time. He or she instead becomes, and is tested as, an ongoing employee. Special rules govern the transition from a newly hired employee to an ongoing employee under which an employee is tested under overlapping measurement periods.

But what happens if a newly hired employee changes his or her status during his or her initial measurement period or the corresponding stability period? The final regulations provide the following rules:

- ***Full-time employees***

A newly-hired employee that is not a new variable hour employee, a new seasonal employee or a new part-time employee—i.e., a full-time employee—must be offered coverage beginning no later than the first day of the fourth full calendar month of employment, provided, of course, that the employee is still employed on that day.

What coverage the employer offers under this rule makes a difference. Where the employer's offer of coverage fails to provide minimum value, the employer is not subject to an assessable payment under Code § 4980H(a) with respect to the employee during the three-and-a-fraction month period, but the employer remains subject to the assessable payment

under Code § 4980H(b). If the offer of coverage provides minimum value, however, the employer also will not be subject to an assessable payment under Code § 4980H(b) during that period.

Thereafter, the employer determines an employee's status as a "full-time employee" based on the employee's hours of service for each calendar month from date-of-hire until such time as the employee becomes an ongoing employee.

- ***New variable hour, seasonal, and part-time employees***

In the case of a new variable hour, new seasonal, or new part-time employee who experiences a "change in employment status" during his or her initial measurement period such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected to be full-time, an employer is not be subject to an assessable payment for that employee until (i) the first day of the fourth full calendar month following the change in employment status, or (ii) if earlier and the employee is a full-time employee based on the initial measurement period, the first day of the first month following the end of the initial measurement period (including any administrative period).

As in the case of offers of coverage to full-time employees, the nature of the offer of coverage makes a difference. Where the employer's offer of coverage fails to provide minimum value, the employer is not subject to an assessable payment under Code § 4980H(a) with respect to the employee, but the employer remains subject to the assessable payment under Code § 4980H(b). If the offer of coverage provides minimum value, the employer also will not be subject to an assessable payment under section 4980H(b).

NOTE: The relief from penalties under Code §§ 4980H(a) and (b) in the case of changes in employment status mirrors the general rule governing offers of coverage during a stability period, under which the employer will not be subject to an assessable payment as follows:

(i) Code § 4980H(a). The employer will not be subject to an assessable payment under Code § 4980H(a) during the initial measurement period (and any associated administrative period) if the employee who qualifies is offered coverage no later than the first day of the associated stability period (provided the employee is then still employed).

(ii) Code § 4980H(b). If the offer of coverage provides minimum value, the employer also will not be subject to an assessable payment under Code § 4980H(b).

- ***Ongoing employees***

If an ongoing employee experiences a change in employment status before the end of a stability period, the change will not affect the application of the classification of the employee as a full-time employee (or not a full-time employee) for the remaining portion of the stability period. As a result, if an ongoing employee fails to qualify for an offer of coverage during a stability period because the employee's hours of service during the prior measurement period were insufficient for full-time-employee treatment, and the employee experiences a change in employment status that involves an increased level of hours of service, the treatment of the employee as a non-full-time employee during the remainder of the stability period is unaffected.

Examples

(1) Part-time employee gets promoted into a full-time position

A new part-time employee who transfers to a full-time position during his or her initial measurement period is treated as full-time under the rule described above. The employer will not be subject to an assessable payment for the period before the first day of the fourth full calendar month following the change in employment status, or if earlier (and the employee averages 30 or more hours of service per week during the initial measurement period) the first day of the first month following the end of the initial measurement period including any administrative period. If the change occurs when the (previously, new) part-time employee is an ongoing employee, however, then no offer is required until the end of the stability period.

NOTE: The rules barring "waiting periods" in excess of 90 days under the Public Health Service Act must also be satisfied. Fortunately, final regulations implementing the waiting period rules generally facilitate simultaneous compliance with both standards.

(2) Part-time employee terminates employment and is subsequently rehired within 13 weeks (or within 26 weeks in the case of an educational organization)

The final regulations include "break-in-service" rules, under which an employee who resumes providing services to an employer "after a period during which the employee was not credited with any hours of service" may be treated as having terminated employment and having been rehired. Such an employee is treated as a new employee upon the resumption of services, only if the employee did not have an hour of service for a period of at least 13 consecutive weeks (or 26 consecutive weeks in the case of an educational organization). In addition, the final regulations include a "parity rule," under which an employee may be treated as rehired after—

"[A] shorter period of at least four consecutive weeks during which no hours of service were credited if that period exceeded the number of weeks of that employee's period of employment with the applicable large employer immediately preceding the period during which the employee was not credited with any hours of service."

For example, if an employee started employment and worked for six weeks, then had a period of eight weeks during which no hours of service were credited, the employer could treat the employee as a rehired employee.

Where the employee has not experienced a break-in-service, he or she is a "continuing employee." As such, his or her status vis-à-vis the application of the look-back measurement method does not change. The analysis set out in item (1) above applies here as well.

(3) Full-time employee transfers to a "variable hour" position, whether or not after a break in service of less than 13 weeks (26 weeks in the case of an educational organization)

The transfer to a position that would qualify as variable hour if occupied by a newly hired employee makes no difference where an employee was originally determined to be, and is hired as, a full-time employee by an employer using the look-back measurement method. This employee will be full-time from date-of-hire until he or she becomes an ongoing employee. Accordingly, his or her treatment is determined month-by-month.

Tags: ACA, Affordable Care Act, assessable payments, full-time employee, initial measurement period, IRS, look-back measurement method, measurement period, monthly measurement method, ongoing employee, part-time employee, seasonal employee, Section § 4980H, stability period, standard measurement period, variable hour employee

The Affordable Care Act—Countdown to Compliance for Employers, Week 20: 9.5% ≠ 9.56% (And Why It Matters to Applicable Large Employers)

Posted By Michael Arnold on August 11th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

While employers sometimes view the Affordable Care Act's employer shared responsibility (or "pay-or-play") rules in isolation, they don't operate that way. Instead, they exist side-by-side with other provisions of the Act. In particular, the Act's rules providing premium tax subsidies to low- and moderate-income individuals correlate with an employer's liability for assessable payments. Of interest to employers is that, generally, where there are no individual subsidies, there are no employer penalties.

In a recently issued revenue procedure (Rev. Proc. 2014-37), the Treasury Department announced adjustments to parameters that impact premium tax subsidies. One of the adjustments made changes to a table used to calculate an individual's premium tax credit. While the adjustments addressed premium tax credits under the Act, it was not immediately apparent what impact, if any, the change would have on employers. As it turns out, the answer is, none.

Background

Generally, U.S. citizens and green card holders are eligible for premium tax credits to assist with the purchase of coverage under a "qualified heath plan" purchased through a public insurance exchange if their household income is between 100 percent and 400 percent of the federal poverty level ("FPL") and they don't have other coverage (e.g. from an employer, unless certain requirements discussed below are satisfied, or under a Government program such as Medicare or Medicaid). (In states that have accepted the Act's expansion of Medicaid, the range is 138 percent and 400 percent of the FPL, since those under 138 percent of the FPL are covered under Medicaid.) To be eligible for premium tax credits, an individual (or "applicable taxpayer") must file a tax return (a joint return if married) and not be claimed as a dependent on another taxpayer's return. The tax credits are "refundable" and "advanceable," i.e., they are paid directly to the qualified health plan.

The Act's provisions relating to premium tax credits are set out in Internal Revenue Code § 36B, under which a taxpayer's premium tax credit is the lesser of two amounts:

- The premiums for the plan or plans in which the taxpayer or one or more members of the taxpayer's family enroll; or
- The excess of the premiums for the applicable second lowest cost silver plan covering the taxpayer's family (i.e., the "benchmark plan") over the "taxpayer's contribution amount."

A taxpayer's contribution amount is the product of the taxpayer's household income and an "applicable percentage" that increases as the taxpayer's household income increases. An eligible individual will qualify for a premium tax credit in an amount equal to the difference between (i) the amount calculated by applying the applicable percentage to household income and (ii) the cost of the monthly premium of the benchmark plan. For 2014, the applicable percentage ranges from 2 percent for taxpayers with income below 133 percent of the FPL and increases incrementally to 9.5 percent for taxpayers with incomes of up to 400 percent of the FPL. An individual with a household income that is between 300 percent and 400 percent of the FPL will qualify for a subsidy in 2014 if the cost of coverage exceeds 9.5 percent of his or her household income.

For tax years after 2014, Congress directed that applicable percentages be adjusted to reflect the excess of the rate of premium growth over the rate of income growth for the preceding calendar year. In Rev. Proc. 2014-37, the Treasury Department and the IRS adjusted the applicable percentages. For tax years beginning after 2014, for example, the 9.5 percent figure cited above is increased to 9.56 percent.

It is here where the confusion creeps in. An individual who has an offer of minimum essential coverage from their employer that is both affordable and sufficiently generous is not eligible for premium subsidies. Colloquially, he or she is said to be "firewalled," i.e., prevented from qualifying, by virtue of the employer's offer of coverage. Final regulations implementing the Act's employer mandate furnish employers with a series of safe harbors governing "affordability" for purposes of determining an employer's exposure for assessable payments under the Act's employer mandate. The affordability safe harbors include W-2 wages, rate-of-pay, and lowest FPL, each of which specifies 9.5 percent as the multiplier. There is no provision in the final regulations requiring adjustment to the affordability safe harbor multiplier. (The final regulations are available here, and a useful set of Q&As issued by the IRS explaining the final regulations are available here.)

The adjustment to a maximum of 9.56 percent in the context of premium subsidy determinations means that an individual with marginally higher income can continue to qualify for a subsidy. It results from an express recognition by Congress, as reflected in the statute, that the rate of medical inflation routinely exceeds the rate of growth in real wages. The affordability safe harbor under the employer shared responsibility rules, on the other hand, is a mere regulatory device. Its purpose is to make it easier for employers to make affordability determinations without knowing each employee's household income.

As a result of the adoption of affordability safe harbors for employer shared responsibility purposes, there is no longer perfect symmetry between these rules and the rules governing premium tax subsidies. An employee who is provided with an offer of affordable employer-provided coverage based on his or her W-2 income may nevertheless qualify for a premium subsidy (e.g., because his or her spouse is self-employed and has a net operating loss) without exposing the employer to an assessable payment. In 2015, this same result could occur where an employee's household income and W-2 wages are the same, but the cost of affordable coverage through a public exchange is between 9.5 and 9.56 percent of household income. In this latter case, an employer's contribution is affordable at 9.5 percent of W-2 wages, but the employee will still qualify for a premium subsidy.

Tags: Affordable Care Act. ACA, Federal Poverty Level, IRS, Medicaid, Medicare

The Affordable Care Act—Countdown to Compliance for Employers, Week 21: Self-Funded Group Health Plans, the Affordable Care Act and National Health Plan Identifier Numbers (HPIDs)

Posted By Michael Arnold on August 4th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) ushered in broad national standards aimed at improving the efficiency and effectiveness of the U.S. health care system. Referred to generically as "administrative simplification," these rules govern the areas of privacy and security of health information, electronic health care transactions and code sets, and unique health identifiers. In the years that followed, the Department of Health and Human Services (HHS) issued comprehensive rules in each of these areas. A summary of these rules is available here.

HIPAA established national standards for transmitting health data electronically and using standard code sets to describe diseases, injuries and other health conditions and problems. The statute envisioned a system that uses one identification number per employer, health plan or payer and health care provider to simplify administration when engaging in the electronic processing of certain standard transactions. Examples of standard transactions include health care eligibility benefit inquiry and responses, health care claim status requests and responses, health care services reviews, health care claim payment/advice, health care claims (medical, dental or institutional), payroll deducted and other group premium payment for insurance products, and benefit enrollment and maintenance. Compliance with the HIPAA rules governing transactions and code sets is required only where information is transmitted between two HIPAA "covered entities" (i.e., certain providers, health plans, and clearinghouses) under one of the transactions referred to above.

HHS published final regulations in 2004 establishing standards for a unique health identifier for health care providers for use in the health care system. In the intervening years, Congress became concerned that under the then current rules, health plans and other entities that perform health plan functions, such as third party administrators and clearinghouses, were able to engage in and report standard transactions with multiple identifiers that differed in length and format. The result was a host of problems that included improper routing of transactions, rejected transactions due to insurance identification errors, and difficulty in determining patient eligibility, among others.

The Affordable Care Act (Section 1104(c)) addresses the problem by requiring health plans to adopt a standard unique health plan identifier (or "HPID"). HHS issued final regulations on September 5, 2012, implementing the HPID requirement. The final regulations establish procedures that a "health plan" may follow to obtain an HPID.

Health plans must obtain an HDIP no later than **November 5, 2014**, except that "small health plans" have until **November 5, 2015**. However, the implementation date for using HPIDs in all standard transactions was deferred until **November 7, 2016**. From and after this latter date, any health plan identified in any standard transaction—whether by another HIPAA covered entity or a business associate—must be referred to using its HPID.

Health plans as HIPAA covered entities

Those entities that are subject to HIPAA's administrative simplification rules—so-called "covered entities" — include the following:

- Providers

Providers include hospitals, doctors, clinics, psychologists, dentists, chiropractors, nursing homes, and pharmacies, but only if they transmit any information in an electronic form in connection with a standard transaction.

- Health plans

Health plans include health insurance issuers/carriers, Health Maintenance Organizations, employer-sponsored group health plans (whether fully-insured or self-funded), and government programs that pay for health care, such as Medicare, Medicaid, and the military and veterans' health care programs.

- Health care clearinghouses

Health care clearinghouses are entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content), or vice versa.

For employers, the definition of "health plan" is particularly curious. The term includes both health insurance products that are routinely and colloquially referred to as "health plans." An employee might, for example, say "my health plan is Blue Cross Blue Shield" when referring to his or her employer's group health plan. HIPAA treats the insurance policy or product and the employer-sponsored group health plan as separate legal entities. While this treatment is counterintuitive and confusing, it is nevertheless consistent with the statutory and regulatory scheme envisioned by Congress.

In the case of a fully-insured group health plan, there are two separate HIPAA-covered entities: the employer and the carrier. Under rules promulgated by HHS, covered entities that engage in joint activities (such as an employer's group health plan and a health insurance issuer or carrier) may operate as an "organized health care arrangement" (OHCA). Thus, in the case of a fully-insured plan, the issuer member of the OHCA will file for the HPID. But in the case of a self-funded plan there is no other HIPAA-covered entity and the self-funded plan must comply on its own. While the regulators readily acknowledge that self-funded group health plans routinely rely on other entities such as third-party administrators to perform health plan functions, the final regulations nevertheless require that the health plan apply for its own HPID.

The final regulations also acknowledge that certain entities that are not HIPAA-covered entities, such as third-party administrators, may from time-to-time need to be identified in a standard transaction. For this purpose, it adopts a data element that will serve as an "other entity identifier" (or "OEID") for these entities. According to the preamble to the final regulations, "[a] OEID is an identifier for entities that are not health plans, health care providers, or individuals, but that need to be identified in standard transactions."

Controlling Health Plans (CHPs) and Subhealth Plans (SHPs)

The final regulations adopt the HPID as the standard unique identifier for health plans. In so doing, the rule defines the terms "Controlling Health Plan" (CHP)—a plan which must obtain an HPID—and "Subhealth Plan" (SHP) — a plan which is eligible to, but not required to, obtain an HPID.

- CHP

A CHP means a health plan that controls its own business activities, actions, or policies; or is controlled by an entity that is not a health plan. If a CHP has a SHP, it must exercise sufficient control over the SHP "to direct its/their business activities, actions, or policies."

• SHP

A SHP means a health plan whose business activities, actions, or policies are directed by a controlling health plan.

To call these newly defined terms unhelpful or perhaps even confusing is an understatement. It appears that a garden variety employer-sponsored group health plan would qualify as a CHP, since it is a "health plan" that "is controlled by an entity that is not a health plan" (i.e., the plan sponsor). What constitutes a SHP is less clear. Presumably, vision, dental or

wellness plans that are wrapped together with a group health plan would qualify. SHPs may, but are not required to, obtain or use their own HPID.

(Nerdy) Comment: The idea that a group health plan may be treated as a separate legal entity is not new. The civil enforcement provisions of the Employee Retirement Income Security Act of 1974 permit an "employee benefit plan" (which includes most group health plans) to be sued in its own name. (ERISA § 502(d) is captioned, "Status of employee benefit plan as entity.") The approach taken under HIPAA merely extends this approach. Separately, there is the question of what, exactly, is an employee benefit plan? In a case decided in 2000, the Supreme Court provided a concise, if modestly counterintuitive answer, saying:

"One is thus left to the common understanding of the word 'plan' as referring to a scheme decided upon in advance . . Here the scheme comprises a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." (*Pegram v. Herdrich*, 530 U.S. 211, 213 (2000)).

The HPID application process

Self-funded plans apply for HPIDs using HHS's "Health Plan and Other Entity Enumeration System" (or "HPOES"), which is sponsored and maintained by CMS's Health Insurance Oversight System. Users are directed to the CMS Enterprise Portal. New users, which will include most self-funded plan sponsors, are required to register and to obtain a username and password. The application process is cumbersome, to say the least. The steps involved are described in a CMS presentation that may be accessed here.

Upon completion of the application process, CMS will provide an e-mail notification containing the plan's HPID.

Some closing observations

The HIPAA administrative simplification rules are primarily provider-focused. Their application to group health plans has been fraught with problems from the start. To say that an employer's group health plan is something legally separate and apart from the employer/plan sponsor is an awkward, though necessary, legal fiction. And to include both health plan policies and products offered by state-licensed insurance carriers and employer-sponsored group health plans under the common heading of "health plan" serves only to compound the confusion.

Self-funded plans are particularly challenged by the structure of the HIPAA privacy and security rules, since they can't partner with a health insurance carrier to form an organized health care arrangement. In practice, however, they often retain health insurance carriers to provide administrative services. While these two arrangements have a great deal in common, the final regulations treat them as fundamentally different. As a consequence, the vast majority of self-funded plans will need to undertake a burdensome application process to obtain an HPID that they may never use.

Tags: ACA, Affordable Care Act, and Subhealth Plans, CHP, CMS Health Insurance Oversight System, Controlling Health Plans, Department of Health and Human Services, Health care clearinghouses, Health Insurance Portability and Accountability Act, Health Plan and Other Entity Enumeration System HPOES, HHS, HIPAA, HPID, IRS, National Health Plan Identifier Numbers, OEID, OHCA, organized health care arrangement, other entity identifier, Self-Funded Group Health Plans, SHP

The Affordable Care Act—Countdown to Compliance for Employers, Week 22: Charting the Future of the Premium Subsidies (and Employer Penalties): Halbig v. Burwell and King v. Burwell

Posted By Michael Arnold on July 28th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS, Supreme Court

Written by Stephen M. Weiner, Alden J. Bianchi, and Roy M. Albert

On July 22, 2014, two federal appellate courts issued conflicting decisions, within hours of each other, regarding the IRS final rule published on May 23, 2012 (the "IRS Rule"), intended to implement the exchange-related tax credit provisions of the Affordable Care Act ("ACA" or the "Act"). The decisions will likely lead to another Supreme Court decision addressing fundamental provisions of the ACA. How these issues are reconciled and resolved will affect the further implementation of Obamacare, and even whether its core policies will survive.

Background

ACA Section 1401 provides for tax credits for eligible taxpayers purchasing insurance "through an *Exchange established by the State* under [ACA Section 1311]" (emphasis added). ACA Section 1311 directs the states to establish health insurance exchanges. It does not refer to federally-facilitated exchanges. Under ACA Section 1321, if a state does not elect to create an exchange that meets federal requirements, the federal government will "establish and operate" one in that state. Currently 16 states and the District of Columbia have established their own exchanges. Thirty-four states rely on federally-facilitated exchanges. The IRS Rule authorized tax credits for insurance purchased on both the state and the federally-facilitated exchanges.

The Decisions

Both decisions addressed whether tax credits are available for residents in the 34 states that have federally-facilitated exchanges. The District of Columbia Court of Appeals (the "D.C. Circuit"), in *Halbig v. Burwell*, said "no"; the Fourth Circuit Court of Appeals (the "Fourth Circuit"), in *King v. Burwell*, said "yes." The decisions turned on readings of the relevant statutory language and application of the principles set out in the 1984 Supreme Court case, *Chevron U.S.A. v. NRDC*.

The *Chevron* test is used to assess whether agency action, in this case the IRS, is within the scope of the agency's authorization, in this case the authority granted by the ACA. The Chevron test has two prongs:

- First, has Congress "directly spoken to the precise question at issue? If the intent of Congress is clear, that is the end of the analysis; for the court as well as the agency must give effect to the unambiguously expressed intent of Congress."
- Second, "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute."

The D.C. Circuit relied principally on the first prong, concluding that the governing language, the specific language of Section 1401, was unambiguous: the IRS cannot provide for tax credits in conjunction with federally-facilitated exchanges.

The Fourth Circuit, weighing the conflicting arguments put forth by both parties and looking at Section 1401 in a broader context, concluded there was ambiguity in a very complex statute, and so it moved on to the second prong of the

Chevron test: whether the IRS Rule was based on "a permissible construction of the statute." This review standard, the Fourth Circuit noted, is highly deferential, with a presumption in favor of finding the agency action valid. Under this prong, in concluding that the IRS Rule should be upheld, the Fourth Circuit was "primarily persuaded by the IRS Rule's advancement of the broad policy goals" of the ACA: a major overhaul of the entire health insurance market in the US, for which the individual mandate and the tax subsidies are integral. Further, the court noted that the IRS Rule took on even greater importance in light of the number of states that chose not to establish their own exchanges.

Potential Impact

If ultimately no premium subsidies are available in states with federally-facilitated exchanges, then millions of individuals in these 34 states will be adversely affected. They will be subject to the individual mandate and not have access to the tax credits that would make their coverage affordable. Some who are willing to risk the penalties may cancel their coverage, and, if they do, the risk pools in those states could be subject to increased adverse selection and become economically untenable. This could spell the end of federally-facilitated exchanges and undermine, in a large majority of the states, the benefits that are key to the ACA.

On the other hand, in those same 34 states, employers subject to the ACA's employer shared responsibility rules would have no exposure for assessable payments on account of employees who receive tax subsidies. Assessable payments are triggered only where one or more employees qualify for a premium tax credit. If no employee is eligible, then there can be no liability for any assessable payments, even if the employer offers no coverage.

Where an employer operates in a mix of states, the analysis is more complicated, but the penalties for offering unaffordable or inadequate coverage could be imposed only with respect to employees living in states that establish exchanges. Or, put another way, employers operating in states that have federally-facilitated exchanges would be placed at a competitive advantage.

What Happens Next

Both cases were decided by three judge panels. Federal appellate courts will sometimes rehear a case before the entire court where the issues involve a matter of exceptional public importance or where the panel's decision conflicts with a prior decision of the court. For the D.C. Circuit decision it has already been reported that the Administration will seek review before the entire panel of judges.

The decision of either court could change. If the two circuits end up agreeing, an appeal to the Supreme Court is still possible. (There are also two other cases—in the 7th (Indiana) and 10th (Oklahoma) judicial circuits—that raise similar issues. Once decisions are handed down in these cases, the dynamic might change.) The Supreme Court may be inclined to take up the matter, even if there is no disagreement among the circuits, if it sees the case as raising important policy issues (which could be the situation here). A decision by the Supreme Court is unlikely to be reached much before June 2015 and could be as long as two years away. For the immediate future, provided that the D.C. Circuit stays its decision, the IRS final rule stays in effect. And open enrollment to purchase insurance on the exchanges for 2015 begins on November 15.

Tags: 4th Circuit, ACA, Affordable Care Act, Burwell, Chevron deference, D.C. Circuit, federally-facilitated exchanges; health insurance exchange, IRS, Supreme Court

The Affordable Care Act—Countdown to Compliance for Employers, Week 23: The Impact of Employment Contract Terms on Variable Hour Employee Status

Posted By Michael Arnold on July 20th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

For applicable large employers (i.e., employers who employed at least 50 full-time and full-time equivalent employees on business days during the preceding calendar year) endeavoring to comply with the Affordable Care Act's employer shared responsibility rules, determining an employee's status as "full-time" is critically important. Final regulations implementing the Act's employer shared responsibility requirements establish two methods—(1) the monthly measurement method and (2) the look-back measurement method—for making that call. The latter, the look-back measurement method, further classifies newly-hired employees as full-time, variable hour, seasonal or part-time. Of these, what constitutes a "new variable hour employee" has proved to be far and away the most confusing.

A recently published set of Questions & Answers made available by the American Bar Association's Section of Taxation, Employee Benefits Committee, provides some helpful insights into the IRS's view of which employees may be properly classified as "variable hour." The Q&As are based on a presentation made by IRS and Treasury officials at the Tax Section's Employee Benefits Committee May 2014 meeting in Washington, D.C. The Q&As reflect the unofficial, individual views of the government participants, which do not necessarily represent formal agency policy. Thus, they may not be relied on as precedent. They are, nevertheless, useful in gaining an understanding of how the regulators think the rules ought to work. One particular Q&A (Q&A 25), entitled "Determining Whether a New Employee is a Variable Hour Employee," deals with the effect of the terms of an employment contract on variable hour status. The IRS response also elucidates other important aspects of the rules governing variable hour employees.

Background

For purposes of the Act's employer shared responsibility rules, an employee is a "full-time employee" if he or she averages at least 30 hours of service per week or 130 hours of service in a calendar month. Under the "monthly measurement method" an employer determines each employee's status as a full-time employee by counting the employee's hours of service for each month. The problem with this method is, of course, that one might not know until after the month is over whether a particular employee is or is not full-time. Recognizing the inherent limitation of the monthly measurement method, the final rules also provide for a "look-back measurement" method. Under the look-back measurement method, an employer determines the status of an employee as a full-time employee during a future period (referred to as the "stability period"), based upon the hours of service of the employee in a prior period (referred to as the "measurement period").

The final regulations prescribe two sets of measurement periods, an "initial measurement period," which generally begins on date-of-hire or the first day of the month following date-of hire, and a "standard measurement period," which is a fixed period of at least three but not more than twelve consecutive months (e.g., the calendar year) selected by the employer. Each measurement period is followed by a corresponding "stability period," which is a period selected by the employer that "immediately follows, and is associated with, a standard measurement period or an initial measurement period." An employer is permitted to interpose an "administrative period" of up to three months between the measurement and stability period.

When applying the look-back measurement method, a newly hired employee must be classified as full-time, variable hour, seasonal, or part-time.

- *Full-time employee*

A "full-time employee" is an employee "who is reasonably expected at the employee's start date to be a full-time employee (and is not a seasonal employee)."

- *Variable hour employee*

An employee is a "variable hour employee" if, based on the facts and circumstances at the employee's start date, the employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain. The final regulations prescribe a series of factors to be applied in making this call. (We explained these factors at length in our April 14, 2014 post.)

- *Seasonal employee*

A "seasonal employee" is an employee who is hired into a position for which the customary annual employment is six months or less.

- *Part-time employee*

A "part-time employee" means a new employee who the employer reasonably expects to be employed on average less than 30 hours of service per week during the initial measurement period, "based on the facts and circumstances at the employee's start date." As is the case with variable hour employee determinations, the final regulations prescribe a series of factors to be applied.

Once an employee has been employed for a full standard measurement period, he or she sheds his or her status as full-time, variable hour, seasonal, or part-time, and instead becomes (and is tested as) an "ongoing" employee. Special rules apply governing the transition from a newly hired employee to an ongoing employee.

The attractiveness of the look-back measurement method is that the employer is not penalized for failing to offer group health plan coverage to newly hired variable hour, seasonal, or part-time employees during their initial measurement period. But if the variable hour, seasonal, or part-time employee is determined to work on average 30 hours or more per week during the initial measurement period, he or she must be offered coverage during the corresponding stability period, despite that he or she no longer works on average 30 hours or more per week, so long as he or she remains employed. A similar approach applies to ongoing employees.

According to the final regulations, for purposes of determining whether an employee is a variable hour employee, an employer "may not take into account the likelihood that the employee may terminate employment . . . before the end of the initial measurement period." This requirement appears, at least at first blush, to contradict one or more of the factors that must be applied in order to establish variable hour status. For purposes of this post, the factor of greatest interest is—

"[W]hether the job was advertised, or otherwise communicated to the new employee or otherwise documented (for example, *through a contract* or job description) as requiring hours of service that would average at least 30 hours of service per week, less than 30 hours of service per week, or may vary above and below an average of 30 hours of service per week. (Emphasis added.)

This particular factor invites the question (excerpted from Q&A 25 referred to above):

"If the terms of the employment contract provide for termination before the end of the initial measurement period, can the employer 'take into account that the employee may terminate employment before the end of the initial measurement period?' What if there is some other restriction (such as the expiration of a work visa) that will make it impossible for the employee's employment to continue through the end of the initial measurement period?"

Variable Hour Determinations—Terms of an Employment Contract

The lead up to the proposed response to Q&A 25 picks up on the apparent contradiction noted above. On the one hand, the factors include the terms of an employment contract or job description, which are known in advance; on the other hand, the regulations also state that "the employer may not take into account the likelihood that the employee may terminate employment before the end of the initial measurement period." The proposed response concludes that the "employer can take into account the provisions of an employment agreement—including the term of the employment agreement—in determining whether an employee is a variable hour employee." The IRS disagrees.

Before examining the IRS's response, it's worthwhile to examine the reasoning of the proposed response. It notes that:

"The purpose of the prohibition on taking into account the likelihood of termination of employment is to avoid making assumptions about employees in positions with high turnover, which would penalize employees who are working full-time hours throughout the initial measurement period. This concern is not present when the employment is of a fixed duration, either by agreement or by operation of law."

This is a compelling, though admittedly narrow, reading of the rule. If the purpose of the variable hour rules was so limited, that is, if the sole purpose of the variable hour rules is to avoid making assumptions about employees in positions with high turnover, then the proposed response would be viable. But the regulators do not read the rule this way. Here's how they see it:

"The terms of an employment contract can be relevant in terms of how many hours a week does the employer expect the employee to work while employed, whatever period that is. If the employer does not know if the hours worked are going to be above 130 hours a month or not then the employer can treat them as variable. *If an employer hires an employee who is going to work 40 hours a week, but the employer only expects the employee to be employed for six months, so it is going to come out to 20 hours a week for the first year, an employer cannot treat the employee as part time.*" (Emphasis added.)

Simply put, variable hour status is based on the employer's inability at the date-of-hire to reasonably determine whether the employee will work full-time over the initial measurement period (while assuming that the employee will be employed for the entire period). The 1,560 hour test is applied at the end of the initial measurement period (not at the beginning) to determine whether the employer must extend an offer of coverage during the corresponding stability period. Viewed this way, the rule barring consideration of early termination makes sense as variable-hour status is based not on tenure but on the *uncertainty and unpredictability* of the employee's work patterns over time. A fixed cap on employee annual hours, whether by contract or otherwise, removes that uncertainty and thus is inconsistent with the premise of variable hour status.

Q&A 25 separately offers the following, welcome clarification relating to seasonal employees.

> "An example of a seasonal employee is a life guard or a ski instructor, but it does not have to be someone whose job is affected by the weather directly. It can just be someone who is peak season working in a hotel or something like that or a summer associate at a law firm for that matter."

Where a newly hired employee is properly determined to be a seasonal employee, then the employer may use the initial measurement period for determining if he or she is full-time. But if the employee is simply on a short-term contract, the employer cannot do that. On this last point, the Service representative helpfully adds that an employer "always has until the beginning of the fourth month to get employee into the plan." Thus, if the employee is only going to be employed for, say, two months, then the employer will not have to make an offer of coverage to the employee under its group health plan.

Tags: ACA, Affordable Care Act, applicable large employers, employer shared responsibility rules, full-time equivalent, initial measurement period, IRS, look-back measurement period, stability period, variable hour employee

The Affordable Care Act—Countdown to Compliance for Employers, Week 24: Can Offers of Group Health Plan Coverage Under Code Section 4980H Qualify as "Bona Fide Fringe Benefits" for Service Contract Act Purposes?

Posted By Michael Arnold on July 15th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, DOL, IRS

Written by Alden J. Bianchi

The Employer Shared Responsibility provisions of the Affordable Care Act ("ACA") generally require "applicable large employers" (i.e., employers who employed at least 50 full-time and full-time equivalent employees on business days during the preceding calendar year) to offer group health plan coverage or face the prospect of having to pay an assessable payment. The McNamara-O'Hara Service Contract Act of 1965—a/k/a the "Service Contract Act" or "SCA"— generally applies to Federal contracts. Contractors subject to the SCA must pay prevailing wage rates and fringe benefits to service employees employed on contracts to provide services to the federal government. The latter fringe benefit obligation may, however, be discharged by paying cash in lieu of fringe benefits. Under the SCA, fringe benefit payments required by Federal or state law ("mandated benefits") may not be used to satisfy the employer's fringe benefit obligations.

The Wage and Hour Division of the U.S. Department of Labor, in a June 11, 2012 memorandum, determined that "employer contributions that are made to satisfy the employers' obligations under the Hawaii-mandated prepaid Health Care Act may not be credited toward meeting the contractor's obligations under SCA." The Wage and Hour Division has not yet opined on whether offers of group health plan coverage are "mandated benefits."

The answer to that question has important consequences to Federal contractors and subcontractors that are subject to the SCA. Should the Wage and Hour Division determine that the ACA is a benefit mandate, group health plan coverage provided to employees to reduce or eliminate exposure under Code § 4980H would ***not*** count toward the $3.71/hour fringe benefit obligation.

Background

Contractors (and subcontractors) subject to the SCA generally have the right to choose how they satisfy the fringe benefit requirements, although the choice may be constrained in the case of employers with collectively bargained employees. The contractor may choose to provide bona fide fringe benefits in kind, e.g., group health benefits, additional sick leave days, or pension/retirement benefits. Alternatively, contractors may discharge their fringe benefit obligations through payment of additional cash wages "in lieu of" benefits.

Most contractors prefer to satisfy the fringe benefit portion of the SCA wage with non-taxable fringe benefits, thereby reducing the marginal payroll tax burden. This is not always possible, however. For example, workers may prefer to receive, and may have the leverage to demand, cash. Nor is it uncommon for employers to provide, or organized workers to negotiate, a choice of non-taxable fringe benefits or cash under a Code § 125 cafeteria plan. But all other things being equal, the contractor paying a bona fide fringe benefit enjoys a competitive advantage over a contractor that pays cash in lieu of benefits.

The Wage and Hour Division explains the particulars of the SCA statutory and regulatory scheme in a suite of resources available here. While comprehensive and well written, nothing in these materials furnishes any clues about how the SCA will coordinate with the ACA's Employer Shared Responsibility provisions. Nor does it give the reader any sense of the contours

of the industry. Employers that compete for Federal contracts and subcontracts, and that are therefore subject to the SCA, fall into three broad categories:

- Large, publicly held contractors, typically though not always in the defense sector;
- Medium and large, closely held employers that are subject to the ACA's employer shared responsibility provisions; and
- Small companies that often have less than 50 full-time and full-time equivalent employees (i.e., not subject to the ACA's employer shared responsibility provisions).

What the Wage and Hour Division decides on the matter of benefit mandates will affect the balance of the competitive advantages enjoyed by each of these groups of companies.

The Wage and Hour Determination

If an offer of group health plan coverage for ACA purposes is determined to be a benefits mandate

If an offer of group health plan coverage for ACA purposes is determined to be a benefits mandate, then, as noted above, the coverage would not count toward the SCA's $3.71/hour fringe benefit requirement. Small employers that are not subject to the ACA's employer shared responsibility requirements will have a competitive advantage over the other two employer cohorts, since they will have no Code § 4980H exposure.

Large and medium-sized employers—i.e., applicable large employers for ACA purposes—might choose to offer a skinny (or "MEC") plan on a contributory basis as a way to avoid exposure under Code § 4980H(a). They would, of course, remain liable under Code § 4980H(b). (For an explanation of skinny plans, please see our June 16, 2014 entry.)

There is one final consequence of "mandated benefit" determination: It leaves the Treasury Department and IRS with little to do. The rules governing the application of Code § 4980H as set out in final regulations issued February 12 of this year include comprehensive rules governing offers of coverage. These rules would apply in the SCA context as they would to any other employer. While an offer of group health plan coverage would affect their exposure under Code § 4980H, it would not qualify as a bona fide fringe benefit for SCA purposes.

If an offer of group health plan coverage for ACA purposes is determined not to be a benefits mandate

If an offer of group health plan coverage for ACA purposes is determined not to be a benefits mandate, then, at a minimum, group health plan coverage would count toward the $3.71/hour fringe benefit requirement. Here, the competitive advantage shifts to the larger employers who are best able to leverage their size to limit the cost of coverage.

The Affordability Determination

Should the Wage and Hour Division find that the ACA does not impose a benefits mandate, the focus shifts to the tax rules. Specifically, the Treasury Department and IRS will need to tell us how to treat the fringe benefit portion of the SCA wage when establishing whether an offer of group health plan coverage is affordable. (Under the statute and the final Code § 4980H regulations, if an employee's share of the premium for employer-provided coverage costs the employee 9.5% or less of the employee's annual household income, the coverage is considered affordable. Because employers generally will not know their employees' household incomes, the final regulations provide three optional affordability safe harbors that are based on the employee's Form W-2 wages or the employee's rate of pay.)

Exclusive offer of group health plan coverage that provides minimum value

Assume that an employer chooses to satisfy the SCA fringe benefit requirement by offering only group health plan coverage that provides minimum value. Assume further that the cost of self-only coverage is less than or equal to the specified fringe benefit value of $3.71/hour. Since the employer is providing the coverage, and there are no other options, it would appear under these circumstances that the employer has no Code § 4980H exposure. The employees in this instance are "firewalled" from premium subsidies, which means that the employer cannot be subject to any assessable payments. Importantly, this conclusion assumes that the premium cost is being paid by the employer despite the fact that the employer has an obligation, rooted in the SCA, to provide fringe benefits or cash.

There are, of course, variations on this theme. For an employee working full-time for an entire year, $3.71/hour would translate into more than $7,000 of annual premiums. This would equal or exceed the cost of self-only coverage in most instances. He or she might have the excess of the fringe benefit wage over the premium cost paid to him or her in cash. Conversely, an employee whose hours are intermittent might have to make up a portion of the premium. In either case, the tax principle remains the same: the SCA fringe benefit wage paid toward premiums is treated as though provided by the employer—which it is, or certainly appears to be.

Choice between group health plan coverage or cash

As noted above, the choice between group health plan coverage or cash in the context of the SCA fringe benefit rules is, for tax purposes, the choice between cash and a non-taxable (or qualified) benefit that is subject to Code § 125. Here, we suspect that the result will be quite different, since amounts contributed to group health plan premiums are treated as employee contributions for employer shared responsibility purposes. The amounts paid toward group health plan coverage are treated as being paid by the employee in this instance. As a consequence, the coverage may or may not be affordable. In this case, the employer will not be subject to assessable payments under Code § 4980H(a), but may incur exposure under Code § 4980H(b).

There is, to be sure, something deeply troubling about this result. Why is it that, when an employer offers only group health plan coverage as the SCA bona fide fringe benefit, the contribution is treated as being provided by the employer, but where a similarly situated employee is offered a choice between group health plan coverage and cash, the contribution is treated as being provided by the employee? While this result is consistent with the underlying tax rules, it's difficult to justify, as a practical matter, in the SCA context.

Tags: ACA, Affordable Care Act, benefits mandate, cafeteria plan, DOL, IRS, McNamara-O'Hara Service Contract Act, SCA, Section 4980H, Wage and Hour Division

The Affordable Care Act—Countdown to Compliance for Employers, Week 25: What Hobby Lobby Means for the Affordable Care Act—Absolutely Nothing

Posted By Michael Arnold on July 7th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, Healthcare, IRS, Supreme Court

Written by Alden J. Bianchi

To call the Supreme Court's recent decision in *Burwell v. Hobby Lobby Stores, Inc.* much-anticipated or highly controversial is an understatement. And, to be clear, any time the Supreme Court weighs in on bed-rock constitutional principle—particularly as it affects the church-state relationship, it is a big deal. But for anyone seeking intelligence on the prospects, efficacy, or fate of the Affordable Care Act, this is not the place to look.

Statutory Background

The Religious Freedom Restoration Act of 1993

The Religious Freedom Restoration Act of 1993 (RFRA) generally prohibits the government from "substantially burdening a person's exercise of religion even if the burden results from a rule of general applicability" unless the Government "demonstrates that application of the burden to the person: (1) Is in furtherance of a compelling governmental interest; and (2) Is the least restrictive means of furthering that compelling governmental interest." According to the Court, RFRA covers "any exercise of religion, whether or not compelled by, or central to, a system of religious belief."

The Affordable Care Act's Contraceptive Mandate

The Affordable Care Act requires that health insurance issuers and group health plans provide coverage for certain women's preventive services. An amendment to the Public Health Service Act requires group health plans and health insurance issuers in the group and individual markets to provide coverage and prohibits them from imposing any cost-sharing requirements for the following services:

- Evidence-based items or services that have in effect a rating of "A" or "B" (i.e., recommended) in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, generally such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

In August, 2011, the HRSA released guidelines that mandated coverage for all FDA-approved contraceptives, but which include a narrow exemption for religious employers. To qualify for this exemption, a religious employer must (i) have the inculcation of religious values as its purpose, (ii) primarily employ persons who share its religious tenets, (iii) primarily serve persons who share its religious tenets, and (iv) be a non-profit organization. Thus, the exemption applied primarily to group health plans established or maintained by churches, synagogues, mosques, and other houses of worship, and religious orders. The religious exemption was subsequently expanded to accommodate religious nonprofit organizations with religious objections to providing coverage for contraceptive services. Under this accommodation, an insurance issuer must

exclude contraceptive coverage from the employer's plan and provide plan participants with separate payments for contraceptive services without imposing any cost sharing requirements on the employer, its insurance plan, or its employee beneficiaries. But the accommodation did not include for-profit, private sector companies.

The Issue in Hobby Lobby

The issue that the Supreme Court was called on to decide is stated succinctly in the opening paragraph of the opinion:

"We must decide in these cases whether the Religious Freedom Restoration Act of 1993 . . . permits the United States Department of Health and Human Services (HHS) to demand that three closely held corporations provide health-insurance coverage for methods of contraception that violate the sincerely held religious beliefs of the companies' owners."

Key Holdings

The Supreme Court's opinion fell squarely along partisan lines: Justice Alito delivered the plurality opinion, which was joined by Justices Roberts, Scalia, and Thomas; Justice Kennedy provided the "swing vote" in a concurring opinion; and Justices Ginsberg, Sotomayor, Breyer and Kagan filed a dissenting opinion.

The Court's central holding was that **the HHS could not by regulation require that group health plans of closely-held businesses cover contraceptive services that violate the sincerely held religious beliefs of the companies' owners.**

Other key holdings from the decision include the following:

- **The RFRA applies to regulations that govern the activities of closely held for-profit corporations.**

The Court rejected HHS's claim that Hobby Lobby and other companies involved in the case could not sue because they are for-profit corporations, and that the owners cannot sue because the regulations apply only to the companies. According to the Court, this would leave merchants with a difficult choice: give up the right to seek judicial protection of their religious liberty or forego the benefits of operating as a corporation. Simply put, corporations are people for RFRA purposes.

- **HHS's contraceptive mandate substantially burdens the exercise of religion.**

The Court determined that the HHS regulations governing contraceptive coverage violate the sincere religious belief of the claimants that life begins at conception. Noting that, "[i]f they and their companies refuse to provide contraceptive coverage, they face severe economic consequences."

- **HHS failed to show that the contraceptive mandate is the least restrictive means of furthering the government's interest**

The Court assumed "that the interest in guaranteeing cost-free access to the four challenged contraceptive methods is a compelling governmental interest," but it was not persuaded that this was the least restrictive means of furthering that interest. The Court faulted HHS for failing to show that it "lacks other means of achieving its desired goal without imposing a substantial burden on the exercise of religion." For example, might it simply extend the accommodation that HHS has already established for religious nonprofit organizations to non-profit employers with religious objections to the contraceptive mandate?

The Hobby Lobby Case and the Affordable Act

The ACA includes about twenty different insurance market reforms that include required coverage of adult children up to age 26, a bar on pre-existing conditions, required coverage of preventive health services with no cost-sharing (i.e., deductibles and co-pays), a ban on lifetime limits and annual limits, a prohibition on discrimination under insured group health plans, rules governing provider choice, rules governing uniform summaries of benefits and coverage, appeals process mandates, a ban on rescissions of coverage (except in the case of fraud or intentional misrepresentations), premium rebates for purchasers of certain health insurance, and access to additional medical data, among others. The contraceptive mandate is a part of one particular reform, i.e., the reform relating to preventive health services.

Moreover, the decision of the Court is a narrow one: ***the manner in which HHS implemented the contraceptive services mandate is problematic only when applied to closely held businesses.*** We expect that HHS will re-write the rule, perhaps along the lines suggested by the Court.

Supreme Court decisions implicating any of the Affordable Care Act's provisions are routinely seized on by proponents and opponents of the Act as evidence of the correctness of their position. Their positions are then picked up by and amplified in media coverage, often resulting in confusion on the part of the public or by employers. From the perspective of Constitutional scholars, this decision may have important significance, but to employers implementing the requirements of the Act, it means little. The challenge for HHS is to ensure access to contraceptive coverage while not unnecessarily offending religious beliefs—something it appears to have already accomplished under the religious accommodation rule described above.

Tags: ACA, Affordable Care Act, Hobby Lobby, Religious Freedom Restoration Act, RFRA, Supreme Court

The Affordable Care Act—Countdown to Compliance for Employers, Week 26: Fitting a Round Peg (the Public Health Service Act 90-day Waiting/Orientation Period Rule) into a Square Hole (the 4980H Three-Month Offer of Coverage Rule)

Posted By Michael Arnold on June 30th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Departments of the Treasury/IRS, Labor and Health and Human Services (the "Departments") recently issued a final regulation under the 90-day waiting period limitation, which is included among the Affordable Care Act's (the "Act") insurance market reforms. Though technically included as an amendment to the Public Health Service Act ("PHS Act"), the provision is carried over into ERISA and the Internal Revenue Code. As a result, the requirement applies broadly to group market products issued by state-licensed carriers (or "issuers" in the parlance of the applicable law), and private sector, governmental, tax-exempt and other group health plans, whether fully-insured or self-funded.

Background

Beginning in 2014, a group health plan or health insurance issuer offering group health insurance coverage may not apply any "waiting period" that exceeds 90 days. A group health plan that runs afoul of the 90-day waiting period limit is generally subject to an excise tax of $100 per day per failure, which must be self-reported on IRS Form 8928. For an explanation of the penalties and how they are reported, please visit our April 21, 2014 blog post. Final regulations implementing the requirement were issued February 24 of this year. The final regulations define "waiting period" as the period that must pass before coverage for an employee or dependent (who is otherwise eligible to enroll under the terms of a group health plan) can become effective. Being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). We explained the final regulations in our March 4, 2014 client advisory.

The Orientation Period Final Regulations

Contemporaneous with the publication of the final regulations, the Departments published proposed regulations dealing with "orientation periods" under the 90-day waiting period limitation. The proposed regulations provided that one month would be the maximum allowed length of any reasonable and bona fide employment-based orientation period. An orientation period was envisioned as a period of time during which "an employer and employee could evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin." Under the proposed regulations, if a group health plan conditions eligibility on an employee's having completed a "reasonable and bona fide employment-based orientation period," the eligibility condition would not be considered to be designed to avoid compliance with the 90-day waiting period limitation.

The final regulations follow the proposed rule by permitting a one-month orientation period, which is determined by adding one calendar month and subtracting one calendar day, starting with the date that an employee is in a position that is otherwise eligible for coverage. If, for example, an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. If there is no corresponding date in the next calendar month upon adding a calendar month, then the last permitted day of the orientation period is the last day of the next calendar month. For

example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). According to the final regulations, if a group health plan conditions eligibility on an employee's having completed a reasonable and bona fide employment-based orientation period, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the orientation period does not exceed one month and the maximum 90-day waiting period begins on the first day after the orientation period.

The final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions. It is only after an individual is determined to be otherwise eligible for coverage under the terms of the plan—i.e., after the end of a bona fide orientation period—that the waiting period begins (and from that point must not exceed 90 consecutive calendar days).

According to the preamble to the final regulation:

"Orientation periods are commonplace and the Departments do not intend to call into question the reasonableness of short, bona fide orientation periods. The danger of abuse increases, however, as the length of the period expands. Accordingly, the final regulations provide that one month is the maximum allowed length of an employment-based orientation period. The creation of a clear maximum prevents abuse and facilitates compliance."

But, to be clear, while a plan is permitted to impose substantive eligibility criteria, such as requiring the worker to fit within an eligible job classification or to achieve job-related licensure requirements, "it may not impose conditions that are mere subterfuges for the passage of time." Thus, for example, an employer could not create an artificial non-benefits-eligible job classification to which it assigns new hires for, say, 6 months before moving the employee into a regular, benefits-eligible class, merely to prolong a waiting period beyond 90 days.

The Code § 4980H connection

The rules limiting waiting periods to 90 days are separate from the Act's employer shared responsibility rules, which are the subject of a separate final regulation issued in February of this year, which IRS explained in a useful set of Q&As.

The preamble to the final orientation period regulations emphasizes that:

"Compliance with the final regulations governing waiting periods is not determinative of compliance with section 4980H of the Code, under which an applicable large employer may be subject to an assessable payment if it fails to offer affordable minimum value coverage to certain newly-hired full-time employees by the first day of the fourth full calendar month of employment."

The preamble offers an example in which an applicable large employer that has a one-month orientation period may comply with the 90-day waiting period requirement and Code § 4980H by offering coverage no later than the first day of the fourth full calendar month of employment. But that same employer may not impose a full one-month orientation period and the full 90-day waiting period without risking exposure under Code § 4980H.

While compliance with final regulations governing waiting periods is not determinative of compliance with Code § 4980H, it does facilitate that compliance. An employee hired September 15 must be offered coverage by the next following January 1 (i.e., the first day of the first calendar month immediately following the first three months of employment, provided that the employee is still employed on that day) in order to comply with Code § 4980H; but without the ability to impose an orientation period, that same employee must be offered coverage in December to satisfy the waiting period rule. By imposing an orientation period that delays the commencement of the waiting period, the employer may first make an offer of coverage on January 1 and still comply with both requirements.

The final regulations take effect August 25, 2014.

Tags: 90-day waiting period limitation, ACA, Affordable Care Act, IRS, orientation period, Section 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 27: COBRA, Marketplace Coverage, Stability Periods, and Cafeteria Plan Elections

Posted By Michael Arnold on June 23rd, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Recent developments under the Affordable Care Act and COBRA, and existing rules governing mid-year election changes under cafeteria plans, have combined to make it challenging for certain terminating employees and those employees who experience a reduction in hours to continue health care coverage seamlessly. These developments include newly-issued COBRA notices, rules governing an individual's ability to enroll in qualified health plans through a public exchange or Health Insurance Marketplace (Marketplace) other than during an open enrollment period, and rules relating to offers of coverage by applicable large employers under rules governing stability periods. The challenge relates to the transition from employer-sponsored group health plan coverage into Marketplace coverage.

The U.S. Department of Labor recently revised model COBRA notices (a general notice and an election notice, which are available here) that take into account the availability of coverage under a public exchange or Marketplace established under the Act. The purpose of the new notices is make qualified COBRA beneficiaries aware that, as a result of the Act, they now have an alternative to COBRA that may better suit their needs. According to a contemporaneous set of Frequently Asked Questions:

Some qualified beneficiaries may want to consider and compare health coverage alternatives to COBRA continuation coverage, such as coverage that is available through the [Marketplace]. Qualified beneficiaries may be eligible for a premium tax credit (a tax credit to help pay for some or all of the cost of coverage in plans offered through the Marketplace) and cost-sharing reductions (amounts that lower out-of-pocket costs for deductibles, coinsurance, and copayments), and may find that Marketplace coverage is more affordable than COBRA.

Generally, individuals may elect Marketplace coverage only during an open enrollment period. For coverage commencing in 2014, that period started October 1, 2013 and ended March 31, 2014. Individuals may also qualify for special enrollment periods outside of open enrollment if they experience certain events that include the loss of other minimum essential coverage (e.g., the loss of coverage under an eligible employer-sponsored plan or when COBRA coverage is exhausted). A COBRA qualified beneficiary could drop COBRA coverage during open enrollment even if their COBRA hasn't expired. But he or she would be unable to do so outside of open enrollment. Concerned that earlier model COBRA notices might have led to some confusion in the matter, the Centers for Medicare & Medicaid Services and Center for Consumer Information and Insurance Oversight, in a May 2 bulletin, extended the COBRA special enrollment period for persons eligible for COBRA and COBRA beneficiaries to July 1, 2014. Unit then, an individual who is currently on COBRA can voluntarily drop COBRA coverage and enroll in Marketplace coverage, without having to wait for the next open enrollment period. (This relief applies by its terms only to Federally-facilitated Marketplaces, but the state-based exchanges are encouraged to follow suit.)

An individual who terminates employment, and who thereby loses minimum essential coverage, is permitted to choose COBRA coverage or Marketplace coverage. But unlike COBRA coverage, which is generally retroactive to the date on which coverage is lost, Marketplace coverage generally takes effect prospectively as of the first day of the month following enrollment. Thus, there could be a gap in coverage, unless the employer coverage runs through the end of the month. Under a recent amendment to the rules governing special enrollment periods, the election of Marketplace coverage can be made within 60 days before or after termination. Thus, an employee with fore-knowledge of his or her termination can

time his or her election to avoid a gap. But an employee who is terminated without notice is not so fortunate. This latter employee is left with a choice between COBRA coverage, which may be more expensive but has the benefit of retroactive effect, and Marketplace coverage, which may be cheaper but may result in a gap in coverage. (An employee who is covered under his or her employer's group health plan is denied access to premium tax credits since he or she has other minimum essential coverage. Once an employee terminates employment and coverage is lost, he or she may qualify for subsidized coverage, which is likely far less expensive than unsubsidized COBRA coverage.)

A qualified beneficiary could use COBRA to fill in the gap by (timely) enrolling in COBRA; (timely) enrolling in Marketplace coverage; and then dropping COBRA coverage once the Marketplace coverage takes effect. This process is burdensome however, as it would require affected individuals to know about and comply with two different sets of rules.

NOTE: HHS has a provided useful, web-based tool for determining whether an individual has a special enrollment right. The tool is available here.

The discussion above assumes a termination of employment or a reduction in hours that results in a loss of minimum essential coverage. But what happens to an employee who is employed by an applicable large employer that determines full-time status under the look-back measurement method? (The rules governing the application of the look-back measurement method are set out in final regulations implementing the Act's employer shared responsibility rules). For an individual who is covered under an employer's group health plan and who moves from full-time to part-time status during a stability period, there is no loss of minimum essential coverage. There is, therefore, no special enrollment right. And while the regulators have not issued any guidance explaining how COBRA interacts with the rules governing stability periods, it seems pretty clear that there are no COBRA rights in this instance.

It gets worse: the employee whose hours have been reduced is presumably paying the employee portion of his or her group health premiums pursuant to a cafeteria plan election. Final regulations governing cafeteria plan elections (Treas. Reg. § 1.125-4) generally bar mid-year changes other than in the case of changes in status or changes in cost-or-coverage. There is no change in status since the employee is still on the job. If the employer charges a higher premium to part-time folks—a less than ideal solution, to be sure—then there may be a change in cost, which would permit the employee to make a mid-year change in his or her cafeteria plan election. But even if the employee could drop coverage under the terms of the plan, and even if he or she could change his or her cafeteria plan election, he or she would still be unable to enroll in Marketplace coverage outside of an open enrollment period.

Terminated employees, and employees who reduce hours, present a sympathetic case. That the current rules foster brief but potentially debilitating coverage gaps is an issue that ought to be addressed. Making timely-elected Marketplace coverage retroactive to the date of termination, for example, would go a long way toward easing the transition from employer coverage to coverage under a qualified health plan. Similarly, expanding the cafeteria plan mid-year election rules to permit the employee to move from the employer plan to Marketplace coverage makes a good deal of sense. Employers too would need to ensure that their plans accommodated the transition. None of this sounds too difficult.

This post updates an earlier version.

Tags: ACA, Affordable Care Act, Cafeteria Plans, COBRA, Health Insurance Marketplace, IRS, public exchange, USDOL

The Affordable Care Act—Countdown to Compliance for Employers, Week 28: The Logic, Calculus, and Limits of "Skinny" Plans

Posted By Michael Arnold on June 16th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

It was just over a year ago that the Wall Street Journal published an article entitled, "Employers Eye Bare-Bones Health Plans Under New Law," which highlighted a compliance strategy to minimize employer exposure for assessable payments under the employer shared responsibility provisions of the Affordable Care Act (the "Act") using what has now come to be called either a "skinny" plan or an "MEC" plan. (For an explanation of the issues and the initial stir that the article created, you can read our June 18, 2013 client advisory.) Over the last year, skinny plans have gained some grudging acceptance. And a consensus appears to have emerged to the effect that, while a skinny plan might be limited to preventative services only, the skinny plans appearing in the marketplace generally include a handful of other features, e.g., wellness programs and perhaps an elective (i.e., "non-coordinated") hospital or fixed indemnity feature.

Background

Generally, an applicable large employer (i.e., an employer with an average of 50 or more full-time and full-time equivalent employees during the previous calendar year) can avoid exposure for assessable payments under Code § 4980H(a) if the employer offers its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan." The term "minimum essential coverage" refers to the source of the coverage. Minimum essential coverage includes government sponsored programs, plans in the individual market, grandfathered group health plans, and other coverage as prescribed by regulation. It also includes coverage under an eligible employer-sponsored plan.

While an eligible employer-sponsored plan includes group health plans (whether or not self-funded), it does not include coverage that consists solely of certain HIPAA excepted benefits (e.g., limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity, or other fixed indemnity insurance).

The term "group health plan" is defined with reference to both ERISA and the Internal Revenue Code, but at bottom for large group fully insured plans and for all self-funded plans, the plan must simply provide "medical care" within the meaning of Code § 213(d), which provides, in relevant part:

The term "medical care" means amounts paid for —

A. the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

B. amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

C. amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B) (Emphasis added).

A skinny plan that provides preventative care falls squarely under clause A above.

There is, of course, also the matter of assessable payments under Code § 4980H(b), which applies in instances where an employer does make an offer of coverage sufficient to satisfy Code § 4980H(a), but that offer is either unaffordable or fails to provide minimum value. While there was initially some confusion in the matter, it is now abundantly clear that skinny plans do not provide minimum value. As a consequence, an employer that offers only a skinny plan will be exposed to the latter penalty.

Some have claimed that skinny plans are somehow aggressive or abusive. But that is a claim that is difficult to support. Rather, skinny plans are contemplated by the express terms of the statute: a plan that fails to provide minimum value is subject to penalties under Code § 4980H(b); skinny plans fail to provide minimum value; therefore skinny plans are subject to penalties under Code § 4980H(b). Still others worry that skinny plans fly in the face of the Act's purpose to make comprehensive coverage widely available. This charge may well be correct. In light of the clear text of the statute, however, this is a problem that only Congress can fix.

Uses for Skinny Plans

In some respects, skinny plans are the new "mini-med" plans. Limited benefit (or mini-med) plans were common among employers with large workforces of high-turnover, low wage employees. As the name suggests, benefit coverage was sparse, to say the least, principally due to the very low annual limits. Limited benefit plans have been phased out under the Act's rules barring lifetime and annual limits. But limited benefit plans were never widespread in any meaningful sense, and one suspects that the same will be true with skinny plans, at least as the only available option.

Another, perhaps unforeseen use for skinny plans is as an insurance policy for an employer that chooses to apply the look-back measurement method for determining an employee's status as "full-time," but is worried that it may not be properly identifying variable hour employees in all cases. In this situation, the employer will offer a major medical (i.e., minimum value) plan to all or substantially all of the employees that it determines to be full-time and offer the skinny plan to all employees. That way, if an employee is determined to be variable hour he or she still has an offer of coverage under the skinny plan.

Still other employers appear to be leaning toward a strategy that calls for offering both a major medical plan and a skinny plan to all employees. This permits employees to purchase just the skinny plan in order to avoid the penalty under the individual mandate (i.e., the requirement that all U.S. citizens and green card holders either have minimum essential coverage or pay a tax). Variations on this latter strategy include offers of coverage that are affordable in some instances but not in others. There is little rhyme or reason to the design selection other than each employer's assessment (read, guess) as to whether its exposure under Code § 4980H(b) exceeds the cost of making the major medical coverage affordable.

The Federal Regulators

To the consternation of some who would like to see skinny plans outlawed, the IRS has said little on the matter of skinny plans. And while the Departments of Labor and Health and Human Services are very much a part of the Act's larger legislative scheme, "minimum essential coverage" is first and foremost a creature of the Internal Revenue Code (i.e., Code § 5000A).

This does not mean that the Service is powerless to affect an employer's behavior vis-à-vis skinny plans. Most skinny plans are self-funded, which means that they, along with any major medical coverage that an employer might offer, must still pass muster under the Code § 105(h) rules governing non-discrimination. Here, the problem is not with the skinny plan, which is presumably offered to all employees or predominantly low-paid employees. It is, rather, a problem for the major medical plan. Thus, for example, it should not be possible for an employer to offer major medical coverage to its management team and a skinny plan to the rank-and-file. As a practical matter, however, these rules have been largely honored in the breach by employers and largely ignored by the regulators.

Similar issues will arise in instances in which the major medical plan is fully insured once the Service gets around to issuing rules imposing non-discrimination rules on fully insured arrangements. Thus, the regulators still have a good deal of leverage to encourage employers to make broad-based offers of major medical coverage. That such coverage is offered alongside a skinny plan should trouble no one.

The Role of State Insurance Departments

From time-to-time, rumors surface to the effect that the insurance commission of this state or that is planning to impose rules effectively shutting down skinny plans. And—who knows—they may. But because ERISA preempts state laws relating to employee benefit plans, any state-based action can only impact skinny plans that are fully-insured. As noted above, at least in our experience, the vast majority of skinny plans are self-funded, and therefore beyond the reach of the state regulators. Separately, rumors that first surfaced last summer to the effect that the Department of Health and Human Services was going to come out "any day" to shut down skinny plans seem to have faded.

Tags: ACA, Affordable Care Act, ERISA, IRS, MEC plan, minimum essential coverage, Section 4980H, Skinny Plans

The Affordable Care Act—Countdown to Compliance for Employers, Week 29: Wellness Programs, Smoking Cessation and e-Cigarettes

Posted By Michael Arnold on June 9th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally prohibits discrimination in eligibility, benefits, or premiums based on a health factor, except in the case of certain wellness programs. Final regulations issued in 2006 established rules implementing these nondiscrimination and wellness provisions. The Affordable Care Act largely incorporates the provisions of the 2006 final regulations (with a few clarifications), and it changes the maximum reward that can be provided under a "health-contingent" wellness program from 20 percent to 30 percent. But in the case of smoking cessation programs, the maximum reward is increased to 50 percent. Comprehensive final regulations issued in June 2013 fleshed out the particulars of the new wellness program regime.

Health-contingent wellness programs require an individual to satisfy a standard related to a health factor to obtain a reward. The final rules divide health-contingent wellness programs into the following two categories: activity-only programs, and outcome-based programs. As applied to smoking cessation, an "activity-only program" might require an individual to attend a class to obtain the reward. In contrast, an outcome-based program would require an individual to quit smoking, or least take steps to do so under complex rules governing alternative standards.

Nowhere do the final regulations address the role of electronic cigarettes (or "e-cigarettes"). Simply put, the issue is whether an e-cigarette user is a smoker or a nonsmoker? (According to Wikipedia, an electronic cigarette (e-cig or e-cigarette), "is a battery-powered vaporizer which simulates tobacco smoking by producing a vapor that resembles smoke. It generally uses a heating element known as an atomizer that vaporizes a liquid solution.") But questions relating to e-cigarettes are starting to surface in the context of wellness program administration. Specifically:

1. Is an individual who uses e-cigarettes a "smoker" for purposes of qualifying, or not qualifying, for a wellness program reward, and
2. May a wellness program offer e-cigarettes as an alternative standard, i.e., one that if satisfied would qualify an individual as a non-smoker?

• Is an individual who uses e-cigarettes a "smoker" for purposes of qualifying, or not qualifying, for a wellness program reward?

While the final rules don't mention or otherwise refer to e-cigarettes, they do provide ample clues to support the proposition that smoking cessation involves tobacco use. Here is the opening paragraph of the preamble:

SUMMARY: This document contains final regulations, consistent with the Affordable Care Act, regarding nondiscriminatory wellness programs in group health coverage. Specifically, these final regulations increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20 percent to 30 percent of the cost of coverage. The final regulations further increase the maximum permissible reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. (Emphasis added.)

There is also a discussion in the preamble about alternative standards (79 Fed Reg. p. 33,164 (middle column)), which reads in relevant part:

The Departments continue to maintain that, with respect to tobacco cessation, ''overcoming an addiction sometimes requires a cycle of failure and renewed effort,'' as stated in the preamble to the proposed regulations. For plans with an initial outcome-based standard that an individual not use tobacco, a reasonable alternative standard in Year 1 may be to try an educational seminar. (Footnotes omitted.)

In addition, the final regulations' Economic Impact and Paperwork Burden section is replete with references to tobacco use, as are the examples (see Treas. Reg. § 54.9802-1(f)(4)(vi), examples 6 and 7).

On the other hand, the definition of what constitutes a participatory wellness program refers simply to "smoking cessation" (Treas. Reg. § 54.9802-1(f)(1)(ii)(D)), and the definition of an outcome-based wellness program (Treas. Reg. § 54.9802-1(f)(1)(v)) simply refers to "not smoking." In neither case is there any reference to tobacco.

The Affordable Care Act's rules governing wellness programs are included in the Act's insurance market reforms, which take the form of amendments to the Public Health Service Act that are also incorporated by reference in the Internal Revenue Code and the Employee Retirement Income Security Act (ERISA). By virtue of being included in ERISA, participants have a private right of action to enforce these rules. So an employer that wanted to treat the use of e-cigarettes as smoking in order to deny access to a wellness reward would likely confront arguments similar to those set out above in the event of a challenge.

• May a wellness program offer e-cigarettes as an alternative standard, i.e., one that if satisfied would qualify an individual as a non-smoker?

This is perhaps a more difficult question. May an employer designate e-cigarette use as an alternative standard? Anecdotal evidence suggests that employers are not doing so, at least not yet. But could they do so? And would it make a difference whether the e-cigarette in question used a nicotine-based solution as opposed to some other chemical? (According to Wikipedia, "solutions usually contain a mixture of propylene glycol, vegetable glycerin, nicotine, and flavorings, while others release a flavored vapor without nicotine.") The answer in each case is, it's too soon to tell.

The benefits and risks of electronic cigarette use are uncertain, with evidence going both ways. Better evidence would certainly give the regulators the basis for further rulemaking in the area. In the meantime, the final regulations' multiple references to tobacco, and by implication, nicotine, seem to furnish as good a starting point as any. This approach would require a wellness plan sponsor to distinguish between nicotine-based and non-nicotine-based solutions, which may prove administratively burdensome.

The larger question, which may take some time to settle, is whether e-cigarettes advance or retard the cause of wellness. Absent reliable clinical evidence, regulators and wellness plan sponsors have little to guide their efforts or inform their decisions as to how to integrate e-cigarettes into responsible wellness plan designs. Complicating matters, the market for e-cigarettes is potentially large, which means that reliable (read: unbiased) clinical evidence may be hard to come by. For now, all plan sponsors can do is to answer the questions set out above in good faith and in accordance with their best understanding of the final regulations.

Tags: ACA, Affordable Care Act, e-cigarettes, ERISA, HIPAA, IRS, wellness program

The Affordable Care Act—Countdown to Compliance for Employers, Week 30: The IRS Tells Us that Employer Payment Plans (Really, Really, Really) Don't Work

Posted By Michael Arnold on June 2nd, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The IRS recently issued two Q&As on the subject of employer payment plans, the purpose of which was to again underscore that arrangements purporting to allow an employer to reimburse employees on a pre-tax basis for premiums used to purchase health coverage in the individual market (either inside or outside of a public exchange) violate certain of the Affordable Care Act's insurance market reforms.

The reforms which the IRS has in mind are:

- Public Health Service Act § 2711, which generally bars group health plans from imposing annual or lifetime limits on the dollar amount of benefits (the "annual dollar limit prohibition"); and
- Public Health Service Act § 2713, which requires non-grandfathered group health plans to provide preventive services without imposing any cost-sharing requirements (the "preventive services requirement").

The general reaction among employers to these Q&As was something like, "yeah, we know that… you folks have already made that clear" or something to that effect. Many wondered why the IRS bothered with these Q&As since the matter appeared to be well-settled in IRS Notice 2013-54, which we wrote about here. But it appears that not everyone got the memo—which is what likely prompted the IRS to act. And to drive the point home, the Service noted that an employer sponsoring an offending arrangement will be subject to a $100/day per employee penalty.

Background

The issue of whether pre-tax employer and employee contributions might be applied to the purchase of individual market coverage was first raised in a June 28, 2010 interim final regulation implementing the annual dollar limit prohibition. While this regulation provided that a "stand-alone" health reimbursement account (HRA) would not satisfy the annual dollar limit prohibition, it did not explain exactly which arrangements were (or were not) stand-alone. Further complicating the matter, the annual dollar limit prohibition (as set out in Public Health Service Act § 2711) does not apply to health FSAs within the meaning of Code § 106(c)(2). (Without this statutory exception, health FSAs would no longer exist.) Nor did the interim final regulations address the impact of Revenue Ruling 61-146, under which, if an employer reimburses an employee for the cost of coverage for an individual market policy, the amount of the employer reimbursement may be excludable from gross income under Code § 106.

These omissions led some promoters to continue to market stand-alone heath reimbursement arrangements claiming that their particular product met one or more of these exceptions. This, despite that most if not all of these products would—at least in our view as subsequently confirmed by the IRS—violate the annual dollar limit prohibition and the preventive services requirement under a fair reading of the interim final regulations. The IRS initially responded with a frequently asked question issued January 24, 2013 (FAQs about Affordable Care Act Implementation Part XI, Q&A 3), saying:

Q3: If an employee is offered coverage that satisfies PHS Act section 2711 but does not enroll in that coverage, may an HRA provided to that employee be considered integrated with the coverage and therefore satisfy the requirements of PHS Act section 2711?

No. The Departments intend to issue guidance under PHS Act section 2711 providing that an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in that coverage. Any HRA that credits additional amounts to an individual when the individual is not enrolled in primary coverage meeting the requirements of PHS Act section 2711 provided by the employer will fail to comply with PHS Act section 2711.

This Q&A was followed later in the year with Notice 2013-54, which addressed the questions raised under Code § 106(c)(2) (the FSA exemption is only applicable to FSAs offered through cafeteria plans) and Rev. Rul. 61-146 (imposing new limits on "employer payment plans"). Notice 2013-54 also established clear rules on what it means for a plan to be "integrated" vs. "stand-alone," and it provided some welcome transition relief. To call Notice 2013-54 "definitive" is something of an understatement. In it, the IRS systematically dismantled the basis for any arrangement intended to circumvent the intent, if not the letter, of the 2010 interim final regulations.

Continuing Abuses

A short while before the issuance of the Q&As, there was a lively discussion on a LinkedIn message board on the subject of employer payment plans. The exchange started with a version of the title of this post, viz., employer payment plans really don't work. There followed varying degrees of dissent. That this discussion occurred at all demonstrates that Notice 2013-54 did not have the intended effect in all quarters. This is particularly troubling because, as the IRS has taken pains to point out, the penalties for running afoul of these rules are steep.

More troubling is that these penalties are self-reported (see our earlier post on the subject of penalties), and they apply to large and small employers alike. Thus, employers to whom employer payment plans have been sold as fitting this or that exception to Notice 2013-54 are already subject to penalties. Regrettably, it's a safe bet that these sorts of violations will occur predominantly in small employers with less access to reliable professional advice.

Despite what appear to be clear rules on the subject of employer payment plans, a handful of vendors continue to press ahead offering arrangements under which an employer reimburses employees on a pre-tax basis for premiums used to purchase health coverage in the individual market, with claimed impunity. One recently called to our attention involves what is touted as an "alternative to an Employer Payment Plan that allows tax-free reimbursement of individual health insurance costs." Under this alternative, an employer "reimburses employees for medical care (including health insurance premiums)." The promoter claims that reimbursements are then excludable from employees' taxable income. This prompts us to offer the following observations:

1. If there is a difference between this arrangement and an offending employer payment plan, we are at a loss to see it;
2. The IRS's recent Q&As on the subject, while perhaps duplicative, are (at least in our view) necessary. Unlike formal agency guidance, which is sometimes difficult to understand let alone find, these Q&As are in plain English and they are readily available; and
3. Arrangements that purport to allow an employer to reimburse employees on a pre-tax basis for premiums used to purchase health coverage in the individual market (either inside or outside of a public exchange) do not work as advertised—period, paragraph, end of discussion.

Tags: ACA, Affordable Care Act, Employer Payment Plans, IRS, IRS Notice 2013-54, Public Health Service Act, Revenue Ruling 61-146

The Affordable Care Act—Countdown to Compliance for Employers, Week 31: ERISA Section 510 and Limiting Employee Hours

Posted By Michael Arnold on May 27th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi and Edward A. Lenz

In last week's post, we examined the appropriateness of capping the annual hours of new "variable hour employees" as a way to limit exposure under the Affordable Care Act's employer shared responsibility rules. (These rules are codified at Internal Revenue Code § 4980H and implemented in final regulations issued in February of this year. The IRS has also published a helpful set of Frequently Asked Questions on the subject.) We asserted that the strategy does not work in the case of new employees during the initial measurement period. This week's post examines its application to "ongoing employees."

Background

As we explained previously,

"Whenever Congress draws a line in the sand—such as with exposure for assessable payments under the Affordable Care Act's employer shared responsibility rules—entities subject to regulation (here, applicable large employers) will inevitably seek ways to avoid having to comply."

Nowhere has this rule been discussed more publicly than in connection with efforts on the part of employers to cap hours of (almost exclusively rank-and-file) employees at or under 30 hours per week so as to avoid having to make any offer of minimum essential coverage. Discussions of these and other avoidance strategies inevitably invoke the specter of § 510 of the Employee Retirement Income Security Act (ERISA). In our experience, much of this analysis misses the mark.

ERISA § 510 makes it unlawful for any person to discriminate against a plan *participant* or beneficiary for exercising rights provided by an employee benefit plan. This provision has generally, though not exclusively, been invoked in cases involving pension benefits. Some commentators have predicted a flood of cases under ERISA § 510 aimed at employers that seek to cap hours in order to avoid Code § 4980H exposure, but these claims often overlook that ERISA § 510 confers rights only on plan participants and not on employees generally. And nothing in ERISA or any other Federal law requires employers to offer group health plan coverage. (The issue of "participant" vs. "employee" is treated at length in a recent blog post by Ann Caresani of Porter, Wright, Morris & Arthur LLP, Cleveland, Ohio.)

It would be a serious mistake, however, to think that the participant/employee distinction ends the matter, and that an employer has nothing to fear under ERISA § 510 if it uses an hours cap strategy to prevent employees from achieving full-time status. ERISA § 3(7) defines a "participant" as an employee or former employee "who is or may become eligible for a benefit of any type from an employee benefit plan." In a case going back to 1989 (*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101), the Supreme Court held that this definition includes a former employee who can show "a colorable claim that (1) he will prevail in a suit for benefits, *or that (2) eligibility requirements will be fulfilled in the future*" (pp. 117-18 italics added). This holding was subsequently expanded on (*see, e.g., Shahid v. Ford Motor Co.*, 76 F.3d 1404, 1410 (6th Cir. 1996)) to permit a plaintiff to prevail if he or she can demonstrate that "but for" the employer's misconduct, he or she would continue to have participant status. Thus, an employer cannot discharge an employee to prevent him or her from achieving benefits eligibility and then argue that the former employee is no longer a participant without standing to sue under ERISA § 510.

A more recent case further expanded the reach of ERISA § 510. *Sanders v. Amerimed*, No. 1:13-cv-813 (S.D. Ohio Apr. 25, 2014), involved a claim for group health benefits by a former employee, John Sanders, who was never a participant or beneficiary in his employer's group health plan. The employer argued that Mr. Sanders was not entitled to benefits as a part-time employee, and as such, he lacked standing to bring a claim under ERISA § 510. The court disagreed, holding instead that Mr. Sanders had standing based on ERISA's definition of participant and on evidence that the employer accepted his application and interviewed him for a full-time position. (Ms. Caresani criticizes the court's holding in *Sanders v. Amerimed* as "overreaching," and she may well be correct.)

Although we don't yet know how the courts will interpret ERISA § 510 in the context of the Affordable Care Act's employer shared responsibility rules, we can make some educated guesses. For example, an employee hired into a position for which benefits are not offered (and assuming no other "bad facts" as may have been adduced in *Sanders*) should not be able to demand benefits by invoking ERISA § 510. Rights under ERISA § 510 may arise, however, in the case of full-time employees who are currently covered under an employer's group health plan and who subsequently lose coverage when their hours are reduced. These latter cases will inevitably be fact intensive, and the burden of proof will shift back-and-forth. For example, an employer may assert that the transfer to part-time had nothing to do with group health coverage but was instead motivated by other legitimate business concerns. The burden would then shift to the employee who might cite the employer's public statements that it is limiting or reducing employee hours for purposes of avoiding "pay-or-play" penalties. Whatever the particulars, it should surprise no one if at least *some* of these plaintiffs prevail.

Ongoing Employees and ERISA §510

This brings us to the question of the treatment of "ongoing employees" as defined in the Affordable Care Act. Recall that the final Code § 4980H regulations provide two ways to determine an employee's status as "full-time": the "monthly measurement method" and the "look-back measurement method." Under the latter method, an employer is not required to make an offer of coverage during an initial measurement period to newly hired "variable hour employees," "seasonal employees," and "part-time employees." In last week's post we asserted that an employee whose annual hours are capped at 1560 will not qualify as variable hour. He or she is, instead, likely to be a full-time employee to whom coverage would need to be offered following three full months of employment to avoid penalties under § 4980H and within 90 days to comply with the maximum waiting period allowed under the Public Health Service Act. But once this employee has been employed for a full standard measurement period, he or she will be an ongoing employee, and, as such, an employer is free to impose a cap on hours during the standard measurement period.

The ERISA problem is immediately apparent: Capping the hours of an ongoing employee during a standard measurement period would result in the withdrawal of coverage or at least eligibility for coverage. These individuals "are or may become eligible for a benefit. . . from an employee benefit plan," i.e., they are participants for ERISA purposes. If the employee can demonstrate that the reason an employer imposes a 1,560 hour (or some similar) cap is to reduce exposure for penalties under Code § 4980H, it would seem that the employee would have little difficulty establishing the requisite level of interference required to state a claim under ERISA § 510.

Tags: ACA, Affordable Care Act, ERISA, ERISA § 510, look-back measurement method, monthly measurement method, plan participant, Section 4980H, variable hour employees

The Affordable Care Act—Countdown to Compliance for Employers, Week 32: Why Capping Annual Hours at 1560 Does Not Work

Posted By Michael Arnold on May 19th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi and Edward A. Lenz

Whenever Congress draws a line in the sand—such as with exposure for assessable payments under the Affordable Care Act's employer shared responsibly rules—entities subject to regulation (here, applicable large employers) will inevitably seek ways to avoid having to comply. Also inevitably, some compliance strategies will be perfectly legitimate, while others will not. One approach that falls into the latter category involves capping annual hours of certain, "variable hour" and other employees at 1,560 hours. Simply put, the approach does not work. This post explains why.

The Affordable Care Act's employer shared responsibility rules are codified in Internal Revenue Code § 4980H and fleshed out in excruciating detail in final regulations issued earlier this year. Employers that are subject to these rules ("applicable large employers") are by now generally familiar if not conversant with the rule's basic structure: An applicable large employer is subject to an assessable payment if one or more full-time employees is certified to the employer as having received an applicable premium tax credit or cost-sharing reduction and either:

- The employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage (MEC) under an eligible employer sponsored plan, or
- The employer offers its full-time employees (and their dependents) the opportunity to enroll in MEC under an eligible employer-sponsored plan but the coverage fails to meet requirements for affordability and minimum value.

MEC includes group health plans that are self-insured or are offered in the large or small group market within a State. Code § 36B generally provides a premium tax credit to low- and moderate-income taxpayers who enroll (or whose family members enroll) in a qualified health plan (QHP) through a public insurance exchange. The credit subsidizes a portion of the premiums for the QHP. But the premium tax credit may not subsidize coverage for an individual who is eligible for employer-sponsored coverage that is both affordable and provides minimum value.

Code § 4980H(e)(4)(A) defines the term "full-time employee" to mean "with respect to any month, an employee who is employed on average at least 30 hours of service per week." The final regulations provide two ways to determine an employee's status as full-time: a "monthly measurement method" and a "look-back measurement method." The monthly measurement method tests an employee's full-time status month-by-month. The monthly measurement method works fine for employers who can reasonably determine on the employee's start date whether the employee will work full-time. But for employers of part-time, temporary, and seasonal employees, whose full-time status at the start date is generally unpredictable, the final regulations make available the look-back measurement method as an alternative.

Under both the monthly measurement method and the look-back measurement method, a newly hired full-time employee must receive an offer of coverage by the first day following three full months of employment for the employer to avoid exposure to assessable payments.

Under the look-back measurement method, full-time status for newly hired "variable hour," "seasonal," and "part-time" employees is determined over an initial measurement period of up to 12 months, selected by the employer, during which coverage need not be offered (and with respect to which no assessable payments are due). If the newly hired variable hour, seasonal, or part-time employee works, on average, 30 or more hours per week (or 1560 hours in 12 months), then

coverage must be offered for a corresponding "stability period" that is the same length as the measurement period, but no shorter than 6 months.

- An employee is a "variable hour employee":

"if, based on the facts and circumstances at the employee's start date, the applicable large employer member cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain." The determination of variable hour status is further subject to the application of a series of factors that are explained in our week-37 post.

- A "seasonal employee" is an employee "who is hired into a position for which the customary annual employment is six months or less."
- A "part-time employee" is an employee "who the applicable large employer member reasonably expects to be employed on average less than 30 hours of service per week during the initial measurement period, based on the facts and circumstances at the employee's start date." This determination is further subject to the application of factors established in the final regulations.

The look-back measurement method includes two sets of measurement periods. The first (described above) is the initial measurement period, which generally begins on an employee's date of hire or the first day of the month following. There is also the "standard measurement period," which is a fixed period (e.g., the calendar year or a plan year), which may also be as long as 12 months, and which is also determined by the employer. Once a newly hired variable hour, seasonal, or part-time employee has worked for one full standard measurement period, he or she loses his or her status as such and instead becomes an "ongoing employee."

Ongoing employees are tested during each standard measurement period. If they work, on average, 30 hours per week (or 1,560 hours during a 12 month standard measurement period) during a particular standard measurement period, then they must be offered coverage during the corresponding stability period for the employer to avoid the prospect of an assessable payment.

Some employers have reportedly taken the position that, if they cap a newly hired employee's hours at 1,560 or some lesser amount such as 1,500, they can avoid exposure under the Act's employer shared responsibility rules. This approach—at least as applied to new hires— fundamentally misunderstands how the look-back measurement method is applied. That the hours of a newly hired employee might be capped at 1,560 in a 12-month initial measurement period does not mean that the employee is a variable hour employee.

Recall that to be considered a variable hour employee, the employer must be unable to "determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain." But by capping employee hours at, say, 1,500 hours, the employer has eliminated any question as to whether the employees will work full-time during the initial measurement period (they will not), thus failing the threshold test of uncertainty. Such an employer has also bypassed and failed to consider the factors which the final regulations say employers must consider in making variable hour determinations.

Applying these rules to ongoing employees yields a different result. According to the final regulations:

"[A]n applicable large employer determines each ongoing employee's full-time employee status by looking back at the standard measurement period. . . . If the applicable large employer member determines that an employee was employed on average at least 30 hours of service per week during the standard measurement period, then the applicable large employer member must treat the employee as a full-time employee during a subsequent stability period…" (emphasis added).

Presumably, the employer could cap an ongoing employee's hours at 1,560 during any standard measurement period, in which case the ongoing employee would not be full-time. As a consequence, the employer would face no Code § 4980H exposure for failing to make the requisite offer of coverage. But if this employee was determined as of his or her date-of-hire to be full-time rather than, say, variable hour, the employer would need to withdraw the offer of coverage that it made with respect to the period prior to the employee's transition to ongoing employee status. The withdrawal of coverage under

these circumstances might not pose a problem for employer shared responsibility purposes, but it may raise issues under the Employee Retirement Income Security Act. We will address this latter question in next week's post.

Tags: ACA, Affordable Care Act, applicable large employers, FTE, full-time employee, IRS, MEC, qualified health plan, Section 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 33: The Impact of Value-Based–Plan Designs and Reference Pricing Models on Minimum Value

Posted By Michael Arnold on May 12th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, DOL, IRS

Written by Alden J. Bianchi

Whether a group health plan provides minimum value is central to the application of the Affordable Care Act's employer shared responsibility rules. The particulars of the role of minimum value in determining assessable payments due from applicable large employers are explained in detail in final regulations issued on February 12 of this year. Simply put, an employee who is offered coverage under an eligible employer-sponsored plan that is both affordable and provides minimum value is ineligible for subsidized coverage from a public insurance exchange. As a consequence, the employer will not be liable for any assessable payments under Internal Revenue Code § 4980H(b) with respect to the employee if the employee declines the employer's offer of coverage and instead enrolls in exchange-provided coverage.

A recently issued paper published by the American Academy of Actuaries (the "AAA Report") provides useful background on two important concepts under the Act: actuarial value (AV) and minimum value (MV). The former (AV) plays a key role in establishing the metallic coverage tiers of individual and small group products—Bronze, Silver, Gold, and Platinum—available through public insurance exchanges; and the latter (MV) establishes the level of group health plan coverage that an applicable large employer must offer to avoid penalties under the Act's employer shared responsibility rules. This post focuses on the "minimum value" concept.

Actuarial Value and Minimum Value

Both AV and MV measure the relative generosity of a group health plan, and use a "standard population" as a starting point. In the case of AV, the standard population is individual and small groups; in the case of MV, the standard population is employer group health plans. A plan with 100% AV or MV would pay the total of all "allowed costs of benefits" provided under the plan in full, with no co-pays, deductibles, co-insurance or other cost sharing features. The metallic levels of coverage offered by public exchanges have AVs of 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). Thus, in the case of coverage under a Platinum plan, the plan pays $.90 of every dollar of covered services. Similarly, a Gold plan would pay $.80 of every dollar of covered services, and so on.

Under the Act, a plan fails to offer MV if "the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs." But an MV plan is not the same as a Bronze-level plan offered through a public exchange. Plans offered in the small group market, and policies issued in the individual market, must provide "essential health benefits," i.e., a set of 10 specified covered services that include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. (The particulars of what constitutes essential health benefits are determined state-by-state under rules promulgated by the Department of Health and Human Services.) In contrast, large fully-insured groups and self-funded groups, irrespective of size, are not required to provide "essential health benefits." Nevertheless, the regulators have decreed that MV is determined by dividing:

1. The anticipated covered medical spending for essential health benefits coverage by a typical self-insured group health plan (computed in accordance with the plan's cost sharing rules), by

2. The total anticipated allowed charges for essential health benefits coverage for a typical self-insured group health plan population.

Accordingly, under final rules issued by the Department of Health and Human Services (HHS) and the Treasury Department/IRS, MV is determined with reference to essential health benefits. This means, as a practical matter, an MV plan will, at a minimum, have the characteristics of a major medical plan with high levels of cost-sharing.

Rules promulgated by HHS and Treasury/IRS provide four approaches for establishing that a plan provides "minimum value":

- *Minimum value calculators*. Employer-sponsored plans may determine their MV by entering information about the cost-sharing features of the plan for different categories of benefits into calculators made available by HHS.
- *Design-based safe-harbor checklists*. If the employer-sponsored plan's terms are consistent with or more generous than any one of the safe-harbor checklists, the plan would be treated as providing minimum value.
- *Actuarial certification*. The calculator may not work for plans with "non-standard features," e.g., quantitative limits, such as a limit on the number of physician visits or covered days in the hospital. (The AAA Report refers to these plans as "plan designs not accommodated by the AV and MV calculators.) In these instances, employers will be permitted to determine minimum value by first using the HHS online calculator, then engaging a certified actuary to make appropriate adjustments that take into consideration the nonstandard features. Employer-sponsored plans with nonstandard features of a certain type and magnitude would also have the option of engaging a certified actuary to determine the plan's actuarial value without the use of a calculator.
- *Small group plans*. Plans offered in the small group market are deemed to provide minimum value by virtue of their mandated plan design.

Employer contributions to a Health Savings Account (HSA) and amounts made available under a Health Reimbursement Account (HRA) are generally included in determining minimum value. For example, a plan with a $1,000 annual HRA contribution and a $1,000 deductible is treated as a $0 deductible.

Wellness program incentives also affect MV. A group health plan's share of costs for MV purposes is determined *without* regard to reduced cost-sharing available under a nondiscriminatory wellness program, except that, beginning with the plan year beginning in 2016, in the case of wellness programs designed to prevent or reduce tobacco use, MV is calculated assuming that every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use.

Value-Based Plan Designs

Value-based plan design elements can cause a plan to have "non-standard features" for MV purposes, thereby requiring actuarial review. The following are examples of value-based plan designs that may require modifications to the MV calculator's results in instances where the impact of the design is determined to be "material" (a non-standard plan design feature has a "material" effect if it changes the metal tier or if it changes whether the plan meets the MV threshold):

- Condition-based plan provisions (e.g., reduced cost-sharing to encourage diabetes monitoring/treatment);
- Treatment decisions by insured (e.g., place of service) impacting benefit levels; or
- Wellness incentives in plan design, including employer contributions to HRAs or HSAs that vary based on member involvement in a wellness program.

The AAA Report explains that "it may be sufficient to value the plan based on the least generous cost-sharing options if the resulting value exceeds the required MV since the calculated value will be the lowest expected value for the plan and the test only requires that the plan exceed the MV." Of course, if the least generous plan option fails the required MV, then "additional calculations/adjustments will be necessary." For reasons explained in the report, this is not a simple matter.

Reference Pricing Models

In a "reference pricing model" an employer or insurer establishes a maximum payment it will make for a specific service, e.g. knee surgery. (A report by the NIHCM Foundation entitled *Reference Pricing: Stimulating Cost-Conscious Purchasing and Countering Provider Market Power*, by James C. Robinson, Ph.D., provides a useful primer on reference pricing.) In theory, the reference price is set high enough to ensure that sufficient numbers of providers are available with prices below the limit, yet low enough to restrict reimbursement to the most expensive providers. In practice, however, reference pricing can be used to cap plan costs in ways that some might view as predatory or abusive. In a recent set of Frequently Asked

Questions, the Department of Labor (joined by HHS and the Treasury Department) gave voice to concerns over reference pricing in connection with the Act's rules imposing caps on maximum out-of-pocket limits, saying:

"Reference pricing aims to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs. At the same time, the Departments are concerned that such a pricing structure may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers."

The Department of Labor did not establish any separate standard or rule respecting reference pricing. Instead, the department invited "comment on the application of the out-of-pocket limitation to the use of reference-based pricing." The department went on to state that it is "particularly interested in standards that plans using reference-based pricing structures should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care."

While the AAA Report does not address the matter, reference pricing would in all likelihood constitute a non-standard plan feature for MV calculation purposes. Thus, adjustments to MV would be required in cases in which the effect of the reference pricing is deemed to be material. Presumably, a reference price that is "set high enough to ensure that sufficient numbers of providers are available with prices below the limit, yet low enough to restrict reimbursement to the most expensive providers" would not result in a material adjustment, but a predatory or abusive reference price would.

Tags: ACA, actuarial value, Affordable Care Act, DOL, essential health benefits, HHS, IRS, minimum value, reference pricing, Section 4980H, Treasury Department, value-based plans

The Affordable Care Act—Countdown to Compliance for Employers, Week 34: When Can Carriers Impose Minimum Participation and Minimum Employer Contribution Requirements? (It's Complicated)

Posted By Michael Arnold on May 5th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Commencing with plan and policy years beginning on or after January 1, 2014, the Affordable Care Act amends the Public Health Service Act ("PHS Act") to make three important changes to the rules governing health insurance underwriting practices that apply to the individual and group markets (but not to grandfathered arrangements):

- ***PHS Act Section 2701, Fair Health Insurance Premiums***

Under this provision, premium rates in the individual and small group market may only vary on the basis of (i) individual or family enrollment, (ii) geographic area (premium rates can vary by the area of the country), (iii) age (premium rates can be higher for an older applicant than for a younger applicant, but the ratio of premiums cannot exceed 3:1 for adults), and (iv) tobacco use (premium rates can be higher for smokers, but the ratio cannot exceed 1.5:1).

- ***PHS Act Section 2702, Guaranteed Issue***

This provision generally requires the guaranteed issuance of health insurance coverage in the individual and group market (small and large) under which insurers that offer coverage in the individual or group market generally must accept all applicants for that coverage in that market.

- ***PHS Act Section 2703, Guaranteed Renewability***

Small and large group and individual health insurance coverage must be guaranteed renewable at the option of the plan sponsor or individual, subject to specified exceptions.

This post addresses the last two items—guaranteed issue and guaranteed renewability. Though these two requirements are often referred to collectively as "guaranteed issue and renewability," they arise under two separate and distinct statutory requirements, which differ from one another in ways critically important as they affect minimum participation and employer contribution requirements. ("Minimum participation" refers to the percentage of employees that must elect coverage for a carrier to agree to issue or renew the coverage; and "employer contribution" refers to the minimum employer contribution that is acceptable to the carrier. Both rules are intended to curb adverse selection.)

NOTE: Because self-funded plans are unaffected by the modified community rating, guaranteed issue and guaranteed renewability requirements, stop-loss issuers are free to impose minimum participation and employer contribution requirements at will, subject only to constraints imposed by the market.

The role of the guaranteed issue and guaranteed renewability rules was highlighted in the final regulations issued February 12 under the ACA's employer shared responsibility rules. Brushing aside concerns that an applicable large employer would be penalized for failure to "obtain or maintain coverage" because of its inability to satisfy a health insurance issuer's minimum participation requirements, the regulators opined:

"In the large group market, *a minimum participation requirement cannot be used to deny guaranteed issue*. For small employers, such as relatively small applicable large employers, final regulations issued by HHS provide that an issuer must guarantee issue coverage to a small employer during an annual, month-long open enrollment period regardless of whether the small employer satisfies any minimum participation requirement. See 45 CFR 147.104(b)(1)." [79 Fed. Reg. at p. 8,566] (Emphasis added).

This rational is only partially responsive. The concern raised by the commenters related to both the failure to "obtain"—i.e., guaranteed issue—and "maintain"—i.e., guaranteed renewability—the requisite minimum essential coverage. The response addresses only the former (guaranteed issue), but it is silent as to the latter (guaranteed renewability). To understand what's missing, a brief detour into the particulars of the implementing regulations is in order. 45 CFR § 147.104(b)(1), to which the preamble to the final employer shared responsibility rules refer, provides, in relevant part:

"A health insurance issuer in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group market, a health insurance issuer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year *in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules* as defined in § 147.106(b)(3) [and] pursuant to applicable state law . . . ." (Emphasis added).

The reference to a "plan provision relating to employer contribution or group participation rules" is both comforting and troubling: Comforting because the import vis-à-vis guaranteed issue is clear. In the large group market, minimum participation and/or employer contribution rules are not allowed; and in the small group market they are allowed other than during a designated open enrollment window (November 15 through December 15). The reference is troubling, however, because is alerts us to the fact that the inquiry may not end here.

The problem is 45 CFR § 147.106(b)(3), which reads (in relevant part):

(a) General rule. Subject to paragraphs (b) through (d) of this section, a health insurance issuer offering health insurance coverage in the individual or group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable.

(b) Exceptions. An issuer may nonrenew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:. . .

(3) Violation of participation or contribution rules. In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law. For purposes of this paragraph the following apply:

(i) The term ''employer contribution rule'' means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(ii) The term ''group participation rule'' means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

What this appears to mean—and it's difficult to read this any other way—is that, while a carrier must accept an employer's initial application for group health plan coverage without regard to the carrier's minimum participation or employer contribution standards, the carrier is free to impose those standards at the next renewal. To say that this rule is troublesome is something of an understatement. Will this cause an employer to change carriers each year in order to avoid having to comply with minimum participation or employer contribution requirements? Or will market forces cause carriers to eliminate or at least loosen these rules?

Tags: 45 CFR 147, ACA, Affordable Care Act, employer contribution, Guaranteed Issue, Guaranteed Renewability, IRS, minimum participation, PHS Act, Public Health Service Act

The Affordable Care Act—Countdown to Compliance for Employers, Week 35: ACA, Mental Health Parity, and (the Hazards of the) Final MHPAEA Regulations

Posted By Michael Arnold on April 28th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

With so much attention focused on the particulars of the employer shared responsibility and, to a slightly lesser extent, reporting rules, it's easy to lose sight of other important changes—including final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which we addressed here and discuss further below.

The ACA expanded and amended the MHPAEA in certain particulars.

- By including mental-health and substance-use disorder (MH/SUD) benefits as one of the ten essential health benefits, the ACA effectively expanded the reach of MHPAEA to non-grandfathered health plans in the individual and small group markets.
- Before the ACA, MHPAEA applied to group health plans. The ACA extended MHPAEA's requirements to the individual market. As a result, non-grandfathered policies issued in the individual and small group market must provide MH/SUD benefits that comply with MHPAEA.

NOTE: MHPAEA will not apply, however, to policies governed by the HHS 2013 transitional policy (establishing rules under which certain individual or small group market coverage will not be considered out-of-compliance with the ACA's market reform provisions).

- Although grandfathered individual market policies are not required to provide MH/SUD benefits, if they do cover these benefits, the coverage must comply with MHPAEA requirements.

The central challenge of MHPAEA is summed up succinctly in an April 3, 2014 Health Policy Brief issued by the Robert Woods Johnson Foundation:

Traditionally, insurers and employers have covered treatment for mental health conditions differently than treatment for physical conditions. Coverage for mental health care had its own (usually higher) cost-sharing structure, more restrictive limits on the number of inpatient days and outpatient visits allowed, separate annual and lifetime caps on coverage, and different prior authorization requirements than coverage for other medical care. Altogether, these coverage rules made mental health benefits substantially less generous than benefits for physical health conditions.

It is this tradition that the MHPAEA reverses. Disruptions are inevitable. The MHPAEA final rules establish the contours of that disruption, and they set out the operational standards for the new regime.

The ACA's expansion of MHPAEA to individual policies is of little or no concern to employers. But the final MHPAEA regulations are or at least should be of interest to employers, if only because of the host of practical problems that the final rules raise. On the "plus" side, the final MHPAEA regulations provide pretty clear rules for the content of plan documents. The rules are, however, complex, and they raise a host of practical problems. These include the following:

1. The final MHPAEA regulations adopt the classification-by-classification testing approach adopted in an earlier, interim final rule, and they also add some new sub-classifications for such things as multiple network tiers and separate sub-tiers for co-pays for office visits and other items and services. While the added sub-classifications are intended to provide flexibility in response to real-world clinical and treatment conditions, they make a complicated testing structure even more cumbersome.
2. Among other things, MHPAEA imposes parity limits on financial requirements and quantitative treatment limitations. While these limits are easy to understand conceptually, and while they pose little difficulty by way of plan drafting challenges, they are difficult to comply with in practice where an employer—as is often the case with MH/SUD carve-outs—uses one provider for medical and surgical benefits (M/S) and another for MH/SUD benefits. For example, where an employer uses different provider networks for M/S and MH/SUD benefits, are they using the same medical management techniques?
3. The final regulations eliminate an exception in the earlier, interim final rule that allowed for differences in medical/surgical benefits and MH/SUD benefits "to the extent that recognized clinically appropriate standards of care may permit a difference." This will make compliance with rules governing "non-quantitative treatment limitations" far more challenging. Under the final regulations, "parity" means "parity," despite that there are substantive differences between M/S, on the one hand, and MH/SUD benefits, on the other. Simply put, many treatments for M/S benefits do not have a MH/SUD equivalent. For example, intensive outpatient treatments for MH/SUD do not have an internal medicine analog.
4. The final regulations bar coverage restrictions based on geographic location. Thus, plans will not be able to restrict, say, outpatient MH/SUD benefits based on the locus of the treatment.
5. To what extent will small employers (under 50) seek to self-fund to avoid MHPAEA compliance? There are of course other reasons for small employers to self-fund (the minimum loss ratio rules don't apply, the penalties for non-discrimination are more manageable, etc.). There is evidence that this is in fact happening. The final MHPAEA regulations may accelerate this nascent trend.

As a consequence of the final MHPAEA regulations, the focus will be less on getting plan documents to comply and more on operational compliance.

Tags: ACA, Affordable Care Act, IRS, MH/SUD, MHPAEA

The Affordable Care Act—Countdown to Compliance for Employers, Week 36: Hacking the Affordable Care Act's $100/Day Penalties for Insurance Market Reform Violations

Posted By Michael Arnold on April 21st, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Particularly with the issuance of final regulations under the Affordable Care Act's employer shared responsibility rules, employers have been concerned—justifiably—with the pay-or-play penalties. Human resource, finance, even senior management personnel of affected employers (i.e., generally, those employers who employed an average of at least 50 full-time employees on business days during the preceding calendar year) want to know, what's this going to cost me, and what does it mean for the maintenance and operation of our group health plans?

But the penalties imposed under Internal Revenue Code section 4980H (the provision of the Code where the pay-or-play penalties live) are not the only penalties imposed by the Act. The Act's insurance market reforms apply to, and potentially impose penalties on, state-licensed insurance carriers ("health insurance issuers" in the parlance of the Act) in the individual and group markets, as well as group health plans, irrespective of the size of the sponsoring employer or employee organization. These reforms include limits on waiting periods, a ban on rescissions, extension of dependent coverage to age 26, the obligation to issue summaries of benefits and coverage, and many more. (A comprehensive listing of the Act's insurance market reforms prepared by the National Association of Insurance Commissioners is available at here.)

The Act's insurance market reforms took the form of amendments to the Public Health Service Act, which generally apply to health insurance issuers and to self-funded, non-federal governmental group plans, but not to group health plans. Following a pattern first established with the health care continuation rules enacted by the Consolidated Budget Reconciliation Act of 1985 (COBRA), Congress incorporated the Act's insurance market reforms into both the Internal Revenue Code and ERISA. The effect of this incorporation is to extend the rules to employer-sponsored group health plans. (An explanation of the penalties that apply to violations of the Act's insurance market reforms prepared by the Congressional Research Service is available at here.)

Where group health plans are concerned, the most worrisome penalty for violation of the ACA insurance market reforms is the $100 per day penalty imposed during the "noncompliance period" by Internal Revenue Code Section 4980D. The noncompliance period is the period that begins on the date the failure first occurs, and ends on the date the failure is corrected. The penalty is imposed "with respect to each individual to whom such failure relates." Importantly, the tax may be abated upon a showing of "reasonable cause" (e.g., if the person otherwise liable for such tax did not know or if exercising reasonable diligence would not have known that such violation existed). Relief is denied, however, where a failure is due to willful neglect. Code Section 4980D penalties must be self-reported on IRS Form 8928. This self-reporting requirement already applies to infractions involving violations of COBRA, HIPAA or Health Savings Account comparable contributions, among others. The revised Form 8928 is available here, and the accompanying instructions may be accessed here.

Too many employers have simply assumed that their carrier (in the case of fully-insured plans) or their third-party-administrator (in the case of self-funded plans) has handled compliance with the Act's insurance market reforms. In most—but not all—instances their reliance is likely warranted. In recent weeks we have encountered a spate of violations involving the failure of a small group to offer certain mandated essential health benefits (pediatric dental), failure to offer the proper alternative standard under a wellness program (not an insurance market reform issue, but the same conundrum), and the failure to adopt the prescribed limit on waiting periods, among others.

So what is an employer to do?

The regulators have yet to provide rules specific to the waiver of penalties in the case of a violation of the Act insurance market reforms that involves reasonable cause. But under provisions of the Code relating to the filing of information returns generally, penalties may be waived where the violation is due to reasonable cause and not willful neglect. (These rules are found in Internal Revenue Code §§ 6721 and 6724.) Typically, this requires a taxpayer to submit a Statement of Reasonable Cause asking that the penalties be waived. Where an employer discovers an insurance market reform violation, it could file IRS Form 8928 along with a Statement of Reasonable Cause.

Under the existing rules (Treas. Reg. §301.6724-1), to qualify for a waiver, an employer must establish that the failure is due to reasonable cause and is not due to willful neglect. The employer must also demonstrate that it "acted in a responsible manner both before and after the failure occurred."

- To establish that the cause is "reasonable," the employer must demonstrate that either there are significant mitigating factors with respect to the failure, or the failure arose from events beyond the filer's control. (Mitigating factors include, but are not limited to "the fact that prior to the failure the filer was never required to file the particular type of return or furnish the particular type of statement with respect to which the failure occurred.")
- The employer must also establish that it acted in a responsible manner both before and after the failure occurred. This means, among other things, that the correction is made promptly. Correction is considered prompt if it is made within 30 days after the date the violation is discovered or on the earliest date thereafter on which a regular submission of corrections is made.

As explained above, relief is denied where the failure to comply results from willful neglect. Whether ignorance of a insurance market reform rule constitutes willful neglect is not clear—at least not to us. While certain of these rules go back to 2010, others did not take effect until January 1, 2014. Presumably, an employer that first became aware of a violation in, say, 2014, would be able to qualify for a waiver based on reasonable cause. Whether the result would be the same in, say, 2018, is less than clear.

Tags: ACA, Affordable Care Act, COBRA, ERISA, IRS, IRS Form 8928, pay-or-play, Section 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 37: Stalking the Elusive "Variable Hour Employee"

Posted By Michael Arnold on April 14th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi and Ed Lenz (Senior Counsel, American Staffing Association)

For "applicable large employers" (i.e., generally, those employers who employed an average of at least 50 full-time employees on business days during the preceding calendar year), determining which employees are "full-time" employees is central to their efforts to comply with the employer shared responsibility provisions of the Affordable Care Act.

The Act defines the term "full-time employee" to mean "an employee who is employed on average at least 30 hours of service per week," and recently issued final regulations under employer shared responsibility rules provide that, for purposes of determining full-time employee status, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week (provided that the employer applies this equivalency rule on a reasonable and consistent basis). IRS Notice 2011-36 (2011-21 I.R.B. 792) highlights the problem with both definitions:

"A determination of full-time employee status on a monthly basis for purposes of calculating an employer's potential § 4980H liability may cause practical difficulties for employers, employees, and the State Exchanges. These difficulties include uncertainty and inability to predictably identify which employees are considered full-time and, consequently, inability to forecast or avoid potential § 4980H liability. *This issue is particularly acute in circumstances in which employees have varying hours or employment schedules (e.g., employees whose hours vary from month to month or who are employed for a limited period).* If employer-sponsored coverage were limited to employees who satisfied the definition of full-time employee during a month, employees might move in and out of employer coverage as frequently as monthly, which would be undesirable from both the employee's and the employer's perspective, and could also create administrative challenges for the State Exchanges." (Emphasis added).

To address this problem, Notice 2011-36 described and requested comments on a possible "look-back/stability period safe harbor." An expanded version of this safe harbor was included in proposed regulations, under which an employer would not incur a penalty for failing to make an offer of group health plan coverage—or, more accurately, an offer of "minimum essential coverage under an eligible employer-sponsored plan"—to "new variable hour employees," among others, during a "measurement period" of up to 12 months. The final regulations retained the safe harbor, which is now referred to as the "look-back measurement method."

One of the categories of employees to whom the look-back measurement method may be applied is "new variable hour" employees. The final regulations define the term "variable hour employee" to mean:

"[A]n employee if, based on the facts and circumstances at the employee's start date, the applicable large employer member cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain."

In an effort to assist employers to determine variable hour status, the final regulations require employers to apply a set of factors, which include, but are not limited to—

- Whether the employee is replacing an employee who was a full-time employee or a variable hour employee;
- The extent to which the hours of service of employees in the same or comparable positions have actually varied above and below an average of 30 hours of service per week during recent measurement periods; and
- Whether the job was advertised, or otherwise communicated to the new employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average at least 30 hours of service per week, less than 30 hours of service per week, or may vary above and below an average of 30 hours of service per week.

According to the final regulations, "these factors are only relevant for a particular new employee if the employer has no reason to anticipate that the facts and circumstances related to that new employee will be different." No single factor is determinative, and an employer may not take into account the likelihood that the employee may terminate employment before the end of the initial measurement period.

Where an employee is hired by a staffing firm for temporary placement at an unrelated entity the final regulations prescribe the following additional factors:

- Whether employees, as part of their continuing employment with the temporary staffing firm, retain the right to reject assignments;
- Whether other employees in the same position of employment with the temporary staffing firm typically have periods during which no offer of temporary placement is made;
- Whether other employees in the same position of employment with the temporary staffing firm typically are offered temporary placements for differing periods of time; and
- Whether other employees in the same position of employment with the temporary staffing firm typically are offered temporary placements that do not extend beyond 13 weeks.

While the method established by the final regulations for determining which employees are variable hour employees looks eminently reasonable on its face, it also raises a number of questions. Here are some:

(1) What is the difference between the "same or comparable positions" and "the same position"?

There is a curious difference between the two sets of factors: the first, general set of factors refers to "the same or comparable positions," while the second, limited set of factors refers and applies to "the same position of employment." It is not clear what this difference is intended to accomplish (or even if it was intentional). For example, if a staffing firm has a number of verticals (e.g., general staffing/light industrial, IT, finance and health care) must it apply the staffing firm factors vertical-by-vertical, or could it apply the factors on some other basis (e.g., by client)?

(2) How many factors must be present?

Examples included in the final regulations include a clear majority, i.e., three out of four in the staffing context. Will two out of four do? And is one out of four too aggressive?

(3) What are the "other" factors that the final regulations refer to?

The final regulations refer to other factors that may apply, but neither the preamble nor the rule itself gives any indication of what they might be.

(4) Is one factor more important than others?

In the temporary staffing context, could regulators give greater weight to the "13-week" factor? Possibly, but wouldn't that effectively conflict with the rule that says no one factor will be viewed as determinative?

(5) What weight should we accord the term "typically" in the second set of factors?

On the one hand, the final regulations tell us that an employer may not take into account the likelihood that the employee may terminate employment before the end of the initial measurement period. On the other hand, the rule clearly allows new employees to be classified as variable hour based on the historical tenure of employees in the same position. Is this a

contradiction, or simply a recognition that employers should be able to reasonably determine the variable hour status of a particular employee based on what the employer knows about the position to which that employee will be assigned?

Tags: 4980(H), ACA, Affordable Care Act, full-time employee, IRS, large employer, variable hour employee

EMPLOYMENT MATTERS
A blog about current developments and issues in employment, labor and benefits law
MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

The Affordable Care Act—Countdown to Compliance for Employers, Week 38: Congress Eliminates Separate Cap on Deductibles

Posted By Michael Arnold on April 7th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

In a rare display of bipartisanship, Congress voted to eliminate the Affordable Care Act's separate cap on deductibles that applies to individual and small group insurance products. (These limits never applied to large fully-insured groups or to self-funded plans.) While this change affects only a subset of employers, it is nevertheless noteworthy since Congress rarely reaches consensus on *any* modifications to the Act.

Background

The Affordable Care Act includes two cost-sharing limits that take effect for plan and policy years beginning in 2014:

- An aggregate limit on "out-of-pocket maximums" (or "OOPMs") on essential health benefits that applies generally to policies of health insurance in the individual and group markets (small and large) and to group health plans (other than grandfathered plans); and
- A separate limit on deductibles that applies only in the individual and small group markets

The OOPM limits

"Cost-sharing" for OOPM purposes includes deductibles, coinsurance, copayments, or similar charges, and any other expenditure required by a participant for a "qualified medical expense" with respect to essential health benefits covered under the plan. The term "qualified medical expense" generally means any tax-deductible medical expense, but it does not include premiums, billing amounts for non-network providers, or spending for non-covered services. Beginning in 2014, OOPMs for essential health benefits may not exceed the cost-sharing caps imposed on high deductible health plans for a plan year. (For 2014, these amounts are $6,350 for self-only coverage and $12,700 for coverage other than self-only. For 2015, they are $6,600 for self-only coverage and $13,200 for coverage other than self-only.)

Under a transition rule announced in February 2013 that applies only to the 2014 plan year, a group health plan with multiple service providers will be deemed to satisfy the OOPM limit if—

- The plan complies with the OOPM requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage), and
- The plan includes a separate OOPM that applies to nonmedical benefits (e.g., prescription drug coverage), that does not exceed the OOPM limit.

In no case, however, may a group health plan or an insurer impose an annual OOPM maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.

Limit on deductibles

In the case of individual and small group health insurance policies, the Act imposes separate limits to annual deductibles, which may not exceed $2,000 for individual coverage or $4,000 for family coverage. These amounts are indexed for future increases in the cost-of-living (for 2015, $2,050 for individual coverage and $4,100 for family coverage). (Annual deductibles do not apply to preventive health services.)

The Protecting Access to Medicare Act

Signed into law on April 1, 2014, the Protecting Access to Medicare Act eliminates the Affordable Care Act's separate limits on deductibles.

The repeal is generally seen as a victory for consumer-driven health care arrangements, since, according to proponents of the change, allowing higher deductibles offers greater flexibility to tailor health insurance with account-based plans (permitting the option of lower premiums with higher deductibles). According to Natasha Rankin, Executive Director of the Employers Council on Flexible Compensation (in a post by Stephen Miller to SHRM Online):

"This is a real victory for consumer-based health care and consumer-based benefit accounts… [I]t allows small employers to continue to provide affordable medical insurance to their employees, including flexible compensation options such as FSAs, HRAs and HSAs that let employees set aside tax-advantaged dollars to help pay for their health care out-of-pocket and deductible expenses."

Though getting little attention in the aftermath of the new law, there is a second consequence of the new law. The separate limit on deductibles posed something of a challenge in designing Bronze-level and Silver-level plans, i.e., plans with, respectively, 60 and 70 percent actuarial value. The Department of Health and Human Services recognized as much in final regulations implementing the Affordable Care Act's rules governing essential health benefits. According to 45 C.F.R. § 156.130(b)(3):

"A health plan's annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage. . . without exceeding the annual deductible limit."

In other words, the separate cap on deductibles could be exceeded where necessary in order to get to a particular level of actuarial value. As a result of the change in the law, this accommodation is no longer necessary.

Tags: ACA, Affordable Care Act, cost-sharing, deductibles, essential health benefits, IRS, OOPMs, out-of-pocket maximum, Protecting Access to Medicare Act, qualified medical expense

The Affordable Care Act—Countdown to Compliance for Employers, Week 39: Common Law Employees and Offers of Coverage on Behalf of Other Entities under the Final Employer Shared Responsibility Regulations

Posted By Michael Arnold on March 31st, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Distinguishing employees who are full-time from those who are not takes up a good deal of real estate in final regulations published in the Federal Register on February 12 implementing the Act's employer shared responsibility rules (the "final regulations"). When determining whether an employee is a full-time employee, it is also necessary to determine who employs the full-time employee. To identify the proper employer, the final regulations look to the "common law employer/employee" standard. (For a detailed explanation of these standards, please see Bianchi and Lenz, The Common Law Employer Test and the Affordable Care Act — Will Businesses Be Responsible for Temporary Employees Assigned by Staffing Firms? Bloomberg/BNA Tax Management Memorandum (Feb. 14, 2014), available here (note: This article was submitted before the issuance of the final Code § 4980H regulations. The authors are planning to produce an updated version that takes the final regulations into account.)). In two-party employment arrangements, i.e., where the employer hires the employee directly without an intermediary, identifying the common law employer and the common law employee is a simple matter. This determination gets exponentially more complicated, however, when the employee is instead hired through a staffing firm or Professional Employer Organization (PEO).

The question of who is the common law employer/employee is not new. For purposes of the Federal tax code and ERISA, employers have historically been required to distinguish between workers who are their common law employees and workers who are not. This distinction is important, for example, when complying with payroll tax and withholding at the source provisions. It also affects the design and maintenance of tax qualified retirement plans and welfare plans. The Affordable Care Act's employer shared responsibility rules (which are codified at Internal Revenue Code § 4980H) add another, compelling reason to properly determine a worker's status as a common law employee: if at least one of an (applicable large) employer's full-time (common law) employees qualifies for a premium tax credit from a public insurance exchange, then the employer may have liability under the Act's employer shared responsibility requirements if the employer fails to make an offer of group health plan coverage to at least 95% (or 70% in 2015 under a transition rule) of its full-time (common law) employees. What's at stake here is best illustrated with an example.

Employer A has 300 employees, all of whom are full-time. Of these, 250 are direct hires, and 50 are hired through Staffing Firm B. For all months during calendar year 2017, Employer A determines that the 250 direct hires are its common law employees. Employer A makes an offer of coverage under its group health plan to all of these employees. Staffing Firm B also makes an offer of coverage to all of its full-time employees, including the 50 workers placed with Employer A (whom Staffing Firm B has determined are full-time for Code § 4980H purposes). On audit, it is determined that the 50 workers placed through Staffing Firm B are the common law employees of Employer A and not Staffing Firm B. Absent the relief described below, Employer A would be deemed to make an offer of coverage during 2017 not to 100% of its full-time (common law) employees as it anticipated, but rather to only 83%. As a consequence, if at least one of Employer A's employees qualified for a premium tax credit from a public insurance exchange, Employer A would incur a non-deductible excise tax for 2017 of over a half of a million dollars.

Comments submitted in response to the proposed Code § 4980H regulations urged the Treasury Department and the IRS to adopt a special rule under which an offer of coverage would be counted for Code § 4980H purposes if made by another,

unrelated entity—e.g., under the circumstances outlined in the above example or in the case of a multiemployer or single employer Taft-Hartley plan. In response, the final regulations clarify that for purposes of Code § 4980H, an offer of coverage includes an offer of coverage made on behalf of an employer by an unrelated entity. However, where the employer is a client of a "professional employer organization or other staffing firm," there is a further requirement:

"the fee the client employer would pay to the staffing firm for an employee enrolled in health coverage under the plan [must be] higher than the fee the client employer would pay to the staffing firm for the same employee if the employee did not enroll in health coverage under the plan."

The combined reference to "professional employer organization or other staffing firm" is troublesome, in our view. In their informal comments, representatives of the Treasury Department and the IRS, expressing their own, non-binding views, assert (rightly) that these terms have no independent significance. That is, common law employer status does not depend on whether the third-party is a PEO or a staffing firm. But as a practical matter, PEOs and staffing firms are different. At least since 2002 (as a consequence of IRS guidance dealing with 401(k) plans maintained by professional employer organizations), it has been widely if not universally presumed that a PEO is not a common law employer, while the opposite is generally true in the case of mainstream staffing firms. Historically, contract and temporary workers placed by staffing firms have been treated as common law employees of the staffing firm and not the client organization. These conclusions are, to be sure, broad oversimplifications. But they have endured presumably because the multi-factor tests for establishing common law employee status are complex and difficult to administer.

Fortunately, there is nothing to prevent a staffing firm from taking advantage of the special rules relating to "offers of coverage on behalf of other entities," but it will require some modifications to each firm's administrative systems. The rule says nothing about how much higher the fee must be in cases where the worker placed by the staffing firm elects coverage. A nominal amount appears sufficient. What's less clear is whether the increased fee must appear as a higher amount in the bill rate, participant-by-participant, or whether the incremental charge could simply be included in the aggregate bill rate (but with appropriate record-keeping back-up).

Separately, there is a lingering issue not addressed in the final regulation (since it is outside the jurisdiction of the Treasury Department and the IRS): where a staffing firm that makes an offer of coverage to a worker is determined not to be the common law employer, the plan under which the offer is made is most likely a multiple employer welfare arrangement. Such a plan would be required to file a Form M-1 annually with the Department of Labor. If the plan was self-funded, then it might be treated as an unlicensed insurance company for state insurance law purposes. If the plan is fully-insured, in most states it could not cover small groups (many state insurance codes do not permit combining a number of small group plans to make a large group plan). While many of the PEOs that offer group health plan coverage have claimed (and duly report their) MEWA status, to our knowledge no staffing firm has done so to date.

On balance, the provisions of the final regulations governing offers of coverage on behalf of other entities should be welcome. It will take some time, however, for standards and best practices to emerge. The relationship to other Federal laws and state insurance codes will also have to be sorted out.

Tags: ACA, Affordable Care Act, IRS, PEO, Professional Employer Organization, Section 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 40: Limited Non-assessment Periods under the Final Code § 4980H Regulations

Posted By Michael Arnold on March 24th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Final regulations under Code § 4980H published in the Federal Register on February 12 include a new term—***"limited non-assessment period"***—which describes periods for which an applicable large employer (i.e., an employer with an average of 50 or more full-time and full-time equivalent employees on business days during the preceding calendar year) will not be subject to liability under Code § 4980H under circumstances where liability would otherwise attach. While the term is used to good effect (in our view) in the provisions governing the imposition of assessable payments, it also provides a brief but nevertheless useful tour of some of the final regulations' key concepts.

Limited non-assessment periods include the following:

(1) The transition rule for an employer's first year as an applicable large employer.

The final regulations provide, with respect to an employee who was not offered coverage at any point in the prior calendar year, that if an employer offers coverage on or before April 1 of the first year in which the employer is an applicable large employer, the employer will not be subject to an assessable payment (for January through March) under Code § 4980H(a) by reason of its failure to offer coverage to the employee for January through March of that year. And, if the coverage that is provided as of April 1 provides minimum value, the employer will not be subject to an assessable payment (for January through March) under Code § 4980H(b). However, if the employer does not offer coverage to the employee by April 1, the employer may be subject to a Code § 4980H(a) assessable payment for those initial calendar months in addition to any subsequent calendar months for which coverage is not offered. And if the employer offers coverage by April 1 but the coverage does not provide minimum value, the employer may be subject to a Code § 4980H(b) assessable payment for those initial calendar months (in addition to any subsequent calendar months for which coverage does not provide minimum value or is not affordable).

This rule applies only during the first year for which an employer is an applicable large employer (even if the employer later falls below the 50 employee threshold and then expands and again becomes an applicable large employer).

(2) The application of Code § 4980H for the three full calendar month period beginning with the first full calendar month in which an employee is first otherwise eligible for an offer of coverage under the monthly measurement method.

The final regulations allow employers two testing options for determining an employee's status as a full-time employee: the "monthly measurement method" and the "look-back measurement method." While the former, monthly measurement method, is not new, it was not fully fleshed out until the final rule. Under the monthly measurement method, an employer will not be subject to an assessable payment under Code § 4980H(a) with respect to an employee because of a failure to offer coverage to that employee before the end of the period of three full calendar months beginning with the first full calendar month in which the employee is otherwise eligible for an offer of coverage if the employee is offered coverage no later than the day after the end of that three-month period. (That the employee must "otherwise [be] eligible for an offer of coverage" means, among other things, that the coverage must already be in place.) If the coverage for which the

employee is otherwise eligible provides minimum value, the employer is also not subject to an assessable payment under Code § 4980H(b).

This rule applies only once per period of employment of an employee and applies with respect to each of the three full calendar months for which the employee is otherwise eligible for an offer of coverage under a group health plan of the employer. Accordingly, the relief may be available even if the employee terminates before that date (and before coverage is offered).

(3) Application of Code § 4980H during the initial three full calendar months of employment for an employee reasonably expected to be a full-time employee at the start date, under the look-back measurement method.

Unlike the rule described in item (2) above, this rule is not new. While the rule works in a manner similar to the rule described above, it serves as an important reminder that, in the case of an employee who is "reasonably expected at his or her start date to be a full-time employee," coverage must be extended relatively quickly—i.e., "no later than the first day of the fourth full calendar month of employment if the employee is still employed on that day."

(4) Failure to offer coverage during the initial measurement period to a new variable hour employee, seasonal employee or part-time employee determined to be employed on average at least 30 hours of service per week under the look-back measurement method.

In contrast to the employee identified in item (3) (i.e., one who "is reasonably expected at his or her start date to be a full-time employee") this rule covers new variable hour, new seasonal, and new part-time employees. These are employees who need not be offered coverage (without risking exposure under Code § 4980H) during their initial measurement period.

(5) Application of Code § 4980H following an employee's change in employment status to a full-time employee during the initial measurement period, under the look-back measurement method.

The proposed regulations included a change in employment status rule for a variable hour or seasonal employee who experiences a change in employment status during the initial measurement period such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected to be employed on average at least 30 hours of service per week. Generally, the employer will not be subject to an assessable payment for such an employee until the first day of the fourth full calendar month following the change in employment status if the employer provides coverage at the end of that period (and to avoid liability under section 4980H(b) the coverage provides minimum value) or, if earlier and the employee is a full-time employee based on the initial measurement period, the first day of the first month following the end of the initial measurement period (including any optional administrative period). The final regulations retain this rule but extend it to apply to any employee who has a change in employment status from part-time employee to full-time employee during the initial measurement period.

The final regulations also provide a special rule that applies when an employee experiences a change in employment status from full-time employee status to part-time employee status. Under this rule, the employer is allowed to apply the monthly measurement method to such an employee within three months of the change if the employee actually averages less than 30 hours of service per week for each of the months following the change in employment status and if the employer has offered the employee continuous coverage that provides minimum value from at least the fourth month of the employee's employment. This rule would apply, for example, to an employee who was hired as a full-time employee (hence, was never tested under an initial measurement period), and who, in connection with a phased retirement program, reduces his or her hours below 30 per week.

(6) Application of Code § 4980H to the calendar month in which an employee's start date occurs on a day other than the first day of the calendar month.

The final regulations include rules governing partial months of coverage. Generally, if an employer member fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not having been offered coverage during that entire month. However, in a calendar month in which a full-time employee's employment terminates, if the employee would have been offered coverage if the employee had been employed for the entire month, the employee is treated as having been offered coverage during that month. Also, an applicable large employer member is not subject to an assessable payment under section 4980H with respect to an employee for the calendar month in which the employee's start date occurs if the start date is on a date other than the first day of the calendar month.

The Affordable Care Act—Countdown to Compliance for Employers, Week 41: What Employers Need to Know About the Final Rules Issued by the Department of Health and Human Services Relating to Transitional Reinsurance Fees, Public Exchanges, Etc.

Posted By Michael Arnold on March 17th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The last few weeks have produced a regulatory frenzy under various provisions of the Affordable Care Act affecting employers:

- On February 12, the Treasury Department and the IRS issued final regulations implementing the Act's employer shared responsibility rules (discussed in an earlier post available here);
- On February 24, the Department of Health and Human Services, the Department of Labor and the Treasury Department/IRS issued final regulations under the Act's rules imposing a ban on waiting periods of more than 90 days (discussed in an earlier post available here);
- On March 10, the Treasury Department and the IRS issued final regulations governing reporting by providers of minimum essential health coverage (under Internal Revenue Code section 6055) (discussed in an earlier post available here); and
- Also on March 10, the Treasury Department and the IRS issued final regulations governing reporting by applicable large employers on health insurance coverage offered under employer-sponsored plans (Internal Revenue Code section 6056) (discussed in an earlier post available here).

Thus, employers and other interested observers might be forgiven if they missed another set of final regulations issued by the Department of Health and Human Services and published in the Federal Register on March 11 relating to "notice of benefit and payment parameters for 2015." While this rule on its face might appear to be of interest to public exchanges and insurance carriers, it nevertheless includes a handful of items that concern employers.

The notice of benefit and payment parameters final regulation is a massive rule that covers, among other topics:

- risk adjustment, reinsurance and risk corridors programs;
- cost sharing limits;
- cost-sharing reduction payments;
- timing for states to decide whether to operate their own exchanges;
- user fees for Federally-facilitated Exchanges (FFEs);
- composite premiums in the Small Business Health Options Program (SHOP);
- privacy and security of personally identifiable information;
- the 2015 open enrollment period;
- the actuarial value calculator;
- the annual limitation in cost sharing for stand-alone dental plans;
- meaningful difference standard for qualified health plans (QHPs) offered through an FFE; and
- patient safety standards for (QHPs).

Set out below are a handful of items of particular interest to employers:

(1) "Composite premiums" for small groups

A key feature of the Act is its reform of insurance underwriting standards. The Act significantly limits the ability of carriers to deny coverage or charge higher premiums to individuals and groups with higher than average health risks. Beginning in 2014, when setting premiums carriers may take into account only age, tobacco use, geographic location, and family size. (Before the Act, carriers routinely took into account factors such as health status and claims experience, age, gender, group size, industry and occupation, geographic location, duration of coverage, and wellness.) When setting rates for small groups, carriers are free to charge different premiums for employees of different ages—a practice that was rare under prior law. The final notice of benefit and payment parameters regulations make clear that carriers are not required to charge age-based rates. Rather, they are free to calculate premiums for the individual members of a small group (excluding tobacco users), but then apply a single, average—or "composite"—premium rate for all covered employees and their beneficiaries. Composite premiums must be established at the start of the policy year, and they may be changed during the course of the year as new employees are added or current employees terminate. Carriers that choose to offer composite rates must offer these rates to all employers in a state small-group market.

(2) Transitional reinsurance fees—amounts and payment

The transitional reinsurance fee is imposed on both fully-insured and self-funded group health plans in 2014, 2015 and 2016. Its purpose is to raise $25 billion to at least in part reimburse carriers that offer coverage in the individual and small group markets for higher than anticipated claims. Only plans that provide "major medical" coverage are subject to the transitional reinsurance fee. Plans that provide excepted benefits (e.g., stand-alone dental and vision benefits) are exempt, as are products issued under a "governmental" book of business (e.g., Medicare Part C or D).

The final regulations confirm that the 2014 assessment of $63 per enrollee must be paid in two installments: $52.50 per enrollee (due January 2015) and $10.50 (due December 2015). For 2015, the reinsurance fee will be $44 per enrollee, also paid in two installments of $33 and $11, respectively. The 2016 transitional reinsurance fee amount has not yet been determined.

(3) Transitional reinsurance fee—exemption for self-administered, self-insured plans

For 2014, under the rules as originally promulgated, all self-funded plans were subject to the transitional reinsurance fee, irrespective of whether they were self-administered or administered by a third party. Generally and historically, self-funded plans maintained by employers have relied on the services of independent third party administrators to handle day-to-day plan maintenance and operation. In contrast, multiemployer plans that are commonly encountered in the collective bargaining setting are typically self-administered. The final regulations confirm that, for 2015 and 2016, self-insured plans that self-administer claims (principally multiemployer plans) are exempt from the reinsurance fee. (For this purpose, plans that contract with unrelated third party provider networks, outsource the administration of pharmacy benefits or excepted benefits, or use only de minimis limited third party services may nevertheless qualify as self-administered.) This change is a boon to multiemployer plans at the (marginal) expense of single employer plans.

(4) Application of excess transitional reinsurance fees

The transitional reinsurance fee amounts are merely estimates of the amounts that the Department of Health and Human Services thinks will be necessary to raise the $25 billion amount specified in the statute. It is possible, however, that revenues from these fees might exceed that amount. According to the final regulations, any excess will be applied to beef-up the reinsurance program based on a formula that benefits carriers rather than the employers that pay the fees in the first instance. (The final regulations also signal the Department of Health and Human Services' intent to audit compliance with the transitional reinsurance fee rules.)

(5) Adjustments to out-of-pocket cost-sharing limits

The Act imposes two sets of cost sharing limits commencing in 2014. The first, which applies to all group health plans, imposes aggregate caps (referred to as "out-of-pocket maximums" or "OOPM") on co-pays, deductibles, and coinsurance, which are the same as those imposed on high deductible health plans (HDHPs), i.e., $6,350 for singles and $12,700 for families in 2014, indexed for later years. Applying the indexation methodology specified by the Act, the final regulations set the out-of-pocket maximums for 2015 at $6,600 for self-only coverage and $13,200 for families. The indexation methodology

that applies to HDHPs is not the same as the indexation methodology that applies to the Act's limits on OOPMs. Thus, the two will diverge in future years.

The second cost sharing limit, which applies only to health insurance policies issued in the individual and small group markets, governs annual deductibles ($2,000 for self-only coverage; $4,000 for family coverage in 2014). The final regulation set the 2015 amounts at $2,050 for self-only coverage and $4,100 for family coverage.

Tags: ACA, Affordable Care Act, IRS

EMPLOYMENT MATTERS
A blog about current developments and issues in employment, labor and benefits law
MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

The Affordable Care Act—Countdown to Compliance for Employers, Week 42: Treasury Department and IRS Issue Final Reporting Rules under Code Section 6055 (Reporting by Providers of Minimum Essential Coverage) and 6056 (Reporting by Applicable Large Employers of Offers of Coverage under Code Section 4980H)

Posted By Michael Arnold on March 10th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

On March 5th, 2014, the Treasury Department and the IRS issued two final reporting rules of critical importance to employers:

- Information Reporting of Minimum Essential Coverage (under Code § 6055, available here); and
- Information Reporting by Applicable Large Employers on Health Insurance Coverage (under Code § 6056, available here).

Background

Code § 6055 imposes on entities that offer minimum essential coverage (i.e., health insurance issuers, certain sponsors of self-insured plans, government agencies and other parties that provide health coverage) the obligation to report certain information about the coverage to the employee and to the IRS. Code § 6056 requires applicable large employers to provide detailed information relating to health insurance coverage that they offer. We explained these rules in a previous post, which described the content of earlier proposed rules under both statutory provisions. In that post, we also made the following prediction:

"While many of the comments submitted in response to the proposed regulations were both thoughtful and practical, many are also difficult to square with the terms of the statute. As a result, the most likely outcome is that the final rules under Code §§ 6055 and 6056 will look a lot like the proposed rules—which look a lot like the statute."

Regrettably and inevitably (at least in our view), our prediction turned out to be accurate: regrettably, since, as one commentator said it, "the [final reporting rules] will be a big, expensive, annoyingly complicated burden for employers;" inevitable because the final rules look a lot like the statute. While the preamble to the final rule evinces what appears to be a sincere effort on the part of the regulators to simplify where possible, and while there may perhaps be room for improvement at the margins, the reporting burdens placed on issuers of minimum essential coverage and on applicable large employers are principally statutory, not regulatory.

The Affordable Care Act imposes mandates on individuals and employers.

• The individual mandate

U.S. citizens and green card holders must generally (i.e., in the absence of an exemption) have health coverage starting in 2014. The fine for failure to have health coverage ranges from the greater of $95 or 1% of income in 2014, to $695 or 2.5% of income in 2016.

• The employer mandate

Applicable large employers (i.e., employers with 50 or more full-time and full-time equivalent employees) face the prospect of an excise tax if one or more of their full-time employees qualify for premium assistance from a public insurance exchange and either

o The employer fails to make an offer of group health plan coverage to at least 95% (70% in 2015) of its full-time employees (and their dependents), in which case there is imposed an annual penalty of $2,000 multiplied by the number of the employer's full-time employees;

o The employer makes the requisite offer of coverage, but the coverage is either unaffordable or fails to provide minimum value, in which case there is imposed an annual penalty of $3,000 multiplied by the number of the employer's full-time employees who qualify for premium assistance.

Where an employer does offer group health plan coverage—or, to be more precise, where the employer makes an offer of minimum essential coverage under an eligible employer-sponsored plan—and where that coverage is both affordable and provides minimum value, then an employee who might otherwise qualify is barred from receiving premium assistance. As a consequence, there can be no excise tax exposure. Though originally stated to go into effect in 2014, these rules were delayed to January 1, 2015.

• The role of Code §§ 6055 and 6056

Code §§ 6055 and 6056 provide the IRS with the information necessary to enforce the individual and employer mandates. Because the individual mandate penalties are determined monthly, the 6055 reporting requirements ask for information on a monthly basis about which employees have elected coverage for themselves and their dependents. Similarly, the 6056 reporting requirements solicit information about the coverage an employer offers month-by-month and whether the coverage is affordable and provides minimum value.

The Final Regulations

Both the 6055 and 6056 reporting requirements take effect commencing in 2015, which means that the first required information returns will be filed in early 2016. In a manner similar to W-2 reporting, both provisions require that information be provided to employees and the government. Reports to employees must be provided by January 31st of the year following the calendar year of coverage. Reports to the government are due annually by March 31st (if filed electronically) of the year following the calendar year of coverage without regard to whether the plan operates on a fiscal or calendar year. Forms may be provided to employees electronically, but only if the recipient has affirmatively consented to receive the statement in electronic format. Applicable large employers will file a combined return, Form 1095-C, that will include information required under both Code §§ 6055 and 6056.

The penalties for failing to file reports under Code §§ 6055 and/or 6056 follow existing "failure-to-file" rules, except that the final regulations offer limited relief for a good faith effort to comply with the reporting rules.

• The final Code §6055 regulations

Reporting is generally required by any person (e.g. health insurance issuers or plan sponsors of self-insured group health plan coverage)—referred to as a "reporting entity"—that provides minimum essential coverage. The obligation to report is imposed separately on each controlled group member employer, although a member of the group may "assist" others to file returns or furnish statements. Reporting is not required for individuals who do not enroll in the employer's plan, nor is reporting required with respect to "supplemental coverage arrangements," which include health reimbursement accounts, health savings accounts, on-site medical clinics (that qualify as excepted benefits), self-insured employer-provided retiree coverage that supplements Medicare benefits, and wellness programs that are coordinated with minimum essential coverage.

The information that must be reported includes the following:

- Name, address, and Employer Identification Number (EIN) of the person required to file the return;

- Name, address and Taxpayer Identification Number (TIN) of the covered employee;
- Name, address, and TIN of each covered dependent;
- The calendar months of coverage for each covered individual; and
- Other information as specified.

Relief is provided in connection with obtaining and reporting of TINs. An employer is not required to report TINs for each dependent if the employer fails to obtain his or her TIN after three separate requests. In the absence of TINs, the employer must instead report each such dependent's date of birth.

The employer must furnish this same information annually to each covered employee along with other information that the IRS specifies.

• The final Code § 6056 regulations

Code § 6056 reporting is required by each member of an applicable large employer's controlled group. One member of the controlled group or a third party may, however, assist the other members. The final regulations establish a "general" reporting method and two alternative methods. Employers can use the general method for some employees and the alternative methods for others (where appropriate). Under the general method, the employer must file a separate return on Form 1095-C (or a substitute statement) for each full-time employee. These separate returns are transmitted to the IRS in the aggregate.

The information that must be reported under the general method includes the following:

- Employer's name, address, EIN and calendar year of reporting;
- Name and telephone number of employer's contact person;
- A certification by calendar month as to whether the employer offered its full-time employees and their dependents the opportunity to enroll in minimum essential coverage;
- The number of the employer's full-time employees for each calendar month during the calendar year;
- For each full-time employee, the calendar months for which minimum essential coverage was available;
- For each full-time employee, by calendar month, the employee's share of the lowest cost monthly premium for self-only coverage offered to that employee that was of minimum value; and
- Name, address, and TIN of each full-time employee during the calendar year and the months during which the employee was covered by the plan.

In addition, the following information will be reported using "indicator codes:"

- Whether the employer's coverage meets the minimum value standard;
- Whether the employee could enroll his or her spouse;
- Total number of employees by calendar month;
- Whether the employee's effective date of coverage was affected by a waiting period, by calendar month;
- Whether the employer is a member of a controlled group, and, if so, the name and EIN of each other member of the group on any day in that reporting year;
- Whether minimum essential coverage was offered to just the employee, just the employee and dependents, just the employee and spouse, or the employee, spouse and dependents;
- When coverage was not offered to an employee, whether this was because the employee was in a waiting period, not a full-time employee, or not employed for a particular month; or whether no exception applies;
- Whether coverage was offered for a month to an employee who was not a full-time employee;
- Whether the employee was covered under the plan; and
- Whether the employer met one of the affordability safe harbors with respect to the employee.

The final regulations also recognize and allow for two alternative (or "simplified") reporting options.

1. Qualifying offers

An applicable large employer may provide limited information in the case of employees (and their dependents) who had a "qualifying offer" of coverage for each month of the year. An offer is a "qualifying offer" if (i) the offer of coverage is made to the employee and his or her spouse and dependents, (ii) the cost for employee-only coverage does not exceed 9.5% of

the federal poverty level (the other affordability safe harbors provided by final regulations issued under Code § 4980H are not available for this purpose), and (iii) the coverage provides minimum value. Where the qualifying offer is made for all 12 months of the calendar year, the employer is permitted to report the coverage using an indicator code. Where coverage is not offered for all 12 months of a calendar year, the employer may use the general rule for the months during which the employee was not offered coverage and designated indicator codes for the other months.

The final regulations also provide a special transition rule that applies only for 2015 under which applicable large employers that have made a qualifying offer of coverage to at least 95% of their full-time employees (and their spouses and dependents) may use a special certification rule.

2. No need to separately identify full-time employees

In instances in which an applicable large employer makes an offer of coverage to most or all of its employees (and their spouses and dependents), there is no need to identify (or specify the number of) full-time employees. To qualify for this alternative (i) the applicable large employer must certify that it offered coverage to at least 98% of all its employees, (ii) the coverage must provide minimum value, and (iii) the coverage must be affordable (using any of the affordability safe harbors in final regulations issued under Code § 4980H).

Tags: ACA, Affordable Care Act, employer mandate, individual mandate, IRC 4980H, IRC 6055, IRC 6056, IRS

The Affordable Care Act—Countdown to Compliance for Employers, Week 43: Coordinating the 3-Month Delay under Employer Shared Responsibility Rules with the Ban on Waiting Periods Longer than 90 Days

Posted By Michael Arnold on March 4th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

So much attention has been paid to the issuance of the final employer shared responsibility regulations that some might have missed the news that final regulations were recently issued under another of the Affordable Care Act's provisions affecting group health plans—i.e., the ban on waiting periods that exceed 90 days. (For a description of these final regulations and a concurrently issued proposed regulation, please see our client advisory of March 4, 2014). The final employer shared responsibility regulations are discussed in previous posts of February 10, 2014, February 18, 2014, and February 24, 2014.

The focus of this post is a narrow but nevertheless important one: **what is the relationship between the permitted 3-month delay in offers of coverage under the Act's employer shared responsibility rules and the Act's rules prohibiting waiting periods of more than 90 days?**

Final regulations implementing the Act's employer shared responsibility rules provide two alternative testing methods for determining an employee's status as a full-time employee: the "monthly measurement method" and the "look-back measurement method." Under both methods, employers are generally permitted to delay offers of group health plan coverage for three full months without exposure for excise tax penalties. (The rule is actually more liberal, since the offer can in certain instances be delayed until the first day of the month following the completion of three full calendar months.) Moreover, in the case of the look-back measurement method, offers of coverage for certain new hires (i.e., new variable hour, new seasonal, and part-time employees) can be delayed for up to 13 months from the employee's start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.

In contrast, final regulations implementing the 90-day waiting period requirement are quite clear that the standard is 90 contiguous days. The regulators expressly declined to adopt a rule under which three months would be deemed to be the equivalent of 90 days. As a result, compliance with the employer shared responsibility rules does not ensure compliance with the ban on waiting periods longer than 90-days. Indeed, the preamble to the final employer shared responsibility regulations acknowledges this to be the case (79 Fed. Reg. at p 8,546):

"Under the section 4980H final regulations, there are times when an employer will not be subject to an assessable payment with respect to an employee although the employer does not offer coverage to that employee during that time. However, the fact that an employer will not owe an assessable payment under section 4980H for failure to offer coverage during certain periods of time does not, by itself, constitute compliance with [the ban on waiting periods longer than 90-days]."

Employers and plans faired marginally better when it comes to coordination with the look-back measurement method. Under the final 90-day waiting period regulations, the "time period for determining whether a variable-hour employee meets the plan's hours of service per period eligibility condition" will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee's start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the

first day of the next calendar month. **Thus, the final regulation aligns the 90-day waiting period rule with the look-back measurement method.** To be clear, however, the first day on which coverage must be offered under the employer shared responsibility rules is the first day on which coverage must be offered under the final 90-day waiting period regulations. The 90-day waiting period does not commence on the first day on which coverage must be offered under the employer shared responsibility rules.

Tags: 4980(H), ACA, Affordable Care Act, IRS, look-back measurement method, monthly measurement method

The Affordable Care Act—Countdown to Compliance for Employers, Week 44: The Top 10 Changes Made by the Final Treasury Regulations Implementing the Affordable Care Act's Employer Shared Responsibility Rules

Posted By Michael Arnold on February 24th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

In last week's post on the topic of the recently issued final regulations under the Affordable Care Act's employer shared responsibility (a/k/a "pay-or-play") rules, we suggested that the final regulations broke little new ground. Instead, we claimed that the final regulations:

- Fixed glitches in the proposed regulations,
- Provided some important clarifications of certain provisions of the proposed regulations; and
- Extended and expanded the transition rules that were provided in the preamble to the proposed regulations.

In the table available in our latest client advisory, we list our choices of the top 10 changes made to the proposed regulation by the final rules. Items 3 and 5 address and fix glitches; items 1, 2, 4, 6, 7 and 8 provide clarifications; and items 9 and 10 include transition rules.

Tags: ACA, Affordable Care Act, IRS, pay-or-play rules

EMPLOYMENT MATTERS
A blog about current developments and issues in employment, labor and benefits law
MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

The Affordable Care Act—Countdown to Compliance for Employers, Week 45: Focus on the Transition Rules under Final Treasury/IRS Regulations Implementing the Affordable Care Act's Employer Shared Responsibility Rules

Posted By Michael Arnold on February 18th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Treasury Department and the IRS last week issued long-awaited final rules implementing the Affordable Care Act's employer shared responsibility (a/k/a "pay-or-play") rules. Originally slated to take effect beginning January 1, 2014, enforcement was delayed a full year by IRS Notice 2013-45. The delay provided affected employers (i.e., those with 50 or more full-time and full-time equivalent employees) with additional time to understand the rules and to consider how best to comply. It also gave health insurance carriers additional time to adapt and gain approval for group health insurance policies that employers could offer to their employees under the new rules.

The final 4980H regulations break little new ground. The basic regulatory structures implementing the Act's employer shared responsibility rules set out in proposed regulations and earlier guidance (discussed in our January 16, 2013 client advisory) remain intact. The final regulations instead:

1. Fix glitches in the proposed regulations;
2. Provide some important clarifications of certain provisions of the proposed regulations; and
3. Extend and expand the transition rules that were provided in the preamble to the proposed regulations.

We addressed the importance of transitional rules in an earlier post. The delay in the enforcement of the employer shared responsibility rules, which came after the proposed regulation's transition relief, led many to wonder whether final regulations under Code § 4980H would include any transition relief. After all, with an additional full 12-month period to come into compliance, why is transition relief necessary?

Not only do the final regulations preserve and extend most of the earlier transition rules, they add some new—very welcome and useful—transition rules. The following is a summary of the transition relief under the final regulations:

(1) Non-calendar year plans

The Act's employer shared responsibility rule apply month-by-month beginning January 1, 2015. This January 1 compliance date works well for a plan with a calendar year plan year, but not so well in the case of plan that has a fiscal plan year. Recognizing that plans with other than a calendar year plan year would need to comply mid-plan year, the proposed regulations provided two sets of transition rules that applied to "fiscal year" plans. The final regulations (which instead refer to "non-calendar year plans") retain and extend these transition rules, and add a new option. The transition rules for non-calendar year plans now include the following:

(a) Pre-2015 eligibility transition relief

The pre-2015 eligibility transition relief applies to employees (whenever hired) who are:

- Eligible for coverage on the first day of the 2015 plan year under the eligibility terms of the plan as of February 9, 2014, (whether or not they take the coverage); and
- Offered affordable coverage that provides minimum value effective no later than the first day of the 2015 plan year.

Where these conditions are satisfied, the employer will not be subject to a potential employer shared responsibility payment until the first day of the 2015 plan year.

NOTE: This relief only applies to employees to whom coverage was previously offered. Thus, penalties may still be imposed for the months in 2015 that are part of the plan year commencing in 2014 with respect to employees to whom coverage was not previously offered.

(b) Significant percentage transition relief (all employees)

If as of any date in the 12 months ending on February 9, 2014, an employer:

- Covers at least one-quarter of its employees (full-time and part-time) under its non-calendar year plan; or
- Offered coverage under the plan to one-third or more of its employees during the open enrollment period that ended most recently before February 9, 2014.

No assessable payment will be due for any month prior to the first day of the 2015 plan year with respect to employees who are offered affordable coverage that provides minimum value by the first day of the 2015 plan year. To qualify for this relief, the employee must not have been eligible for coverage as of February 9, 2014 under any group health plan maintained by his or her employer that has a calendar year plan year.

Unlike the pre-2015 eligibility transition relief described above, an employer that qualifies for this relief and who offers affordable, minimum value coverage commencing with the 2015 plan year has no Code § 4980H exposure for periods before the 2015 plan year.

Relief under this (and the next) rule applies for the period before the first day of the first non-calendar year plan year beginning in 2015 (the 2015 plan year) but only for employers that maintained non-calendar year plans as of December 27, 2012, and only if the plan year was not modified after December 27, 2012, to begin at a later calendar date.

(c) Significant percentage transition relief (full-time employees).

This relief is new to the final regulations, and was added in response to comments complaining that the transition relief provided by the proposed regulations penalized employers with large cohorts of part-time employees who were not offered coverage. This transition rule is similar to the "all employees" rule described above, except that it tests only full-time employees. Under this rule, the plan must cover at least one-third of its full-time employees, or offer coverage to at least one-half or more of its full-time employees during the relevant open enrollment period.

(2) Employers close to the 50 full-time-employee threshold.

Rather than being required to use the full twelve months of 2014 to measure whether it has 50 full-time employees (or equivalents), an employer may measure during any consecutive six-month period (as chosen by the employer) during 2014.

(3) Initial offers of coverage in January 2015

Generally, if an employer fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not having been offered coverage during the entire month. But for purposes of January 2015, if an employer offers coverage to a full-time employee no later than the first day of the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for January 2015.

(4) Dependent coverage

In order to avoid possible exposure for an assessable payment under Code § 4980H, an employer must make an offer of coverage to full-time employees and their dependents. The proposed regulations offered transition relief under which an employer will not be subject to an employer shared responsibility payment solely on account of a failure to offer coverage to dependents for that plan year if the employer takes steps during the 2014 plan year toward satisfying this requirement. The final regulations extend this transition relief to plan years that begin in 2015. The transition relief applies to employers for the 2015 plan year for plans under which (i) dependent coverage is not offered, (ii) dependent coverage that does not constitute minimum essential coverage is offered, or (iii) dependent coverage is offered for some, but not all, dependents. This relief is not available, however, if the employer had offered dependent coverage during either the plan year that begins in 2013 or the 2014 plan year and subsequently dropped that offer of coverage.

(5) Cafeteria plan transition rule

The proposed regulations allowed employers to amend their cafeteria plans to permit employees to elect or revoke health coverage elections mid-year absent a corresponding change in status or cost or coverage change during a non-calendar plan year that began in 2013. This relief was subsequently clarified, but not extended (*see* IRS Notice 2013-71). The final regulations also do not extend this relief.

(6) Transition relief for employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents)

For employers with fewer than 100 full-time employees (including full-time equivalents) in 2014, that meet the conditions described below, the employer shared responsibility rules are delayed until the first day of the 2016 plan year. To be eligible for this relief, an employer will be required to certify that it meets the following conditions:

- The employer must employ on average at least 50 full-time employees (including full-time equivalents) but fewer than 100 full-time employees (including full-time equivalents) on business days during 2014;
- During the period beginning on February 9, 2014 and ending on December 31, 2014, the employer may not reduce the size of its workforce or the overall hours of service of its employees in order to qualify for the transition relief (other than for bona fide business reasons); and
- During the period beginning on February 9, 2014 and ending on the last day of the 2015 plan year, the employer does not eliminate or materially reduce the health coverage, if any, it offered as of February 9, 2014.

(7) Reduction in the 95% "offer of coverage" requirement for 2015

Under the proposed regulations, an employer is deemed to have failed to make an offer of coverage to its full-time employees if it does not offer health coverage or offers coverage to fewer than 95% of its full-time employees and (unless the employer qualifies for the 2015 dependent coverage transition relief) the dependents of those employees, and at least one of the full-time employees receives a premium tax credit. For 2015 (and for any calendar months during a non-calendar year plan year beginning in 2015 that fall in 2016), the 95% threshold is lowered to 70%. (This relief is not necessary for an employer with at least 50 but fewer than 100 full-time employees that qualifies for the delayed effective date described in item (6) above.)

Tags: 4980H regulations, ACA, Affordable Care Act, IRS, pay-or-play rules

The Affordable Care Act—Countdown to Compliance for Employers, Week 45½: Treasury/IRS Issue Long-Awaited Final Regulations under the Affordable Care Act's Employer Shared Responsibility Rules

Posted By Michael Arnold on February 10th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

Breaking with long standing tradition—i.e., issuing important rules on a Friday before a holiday weekend, or (failing that) *any* Friday (hence the reference to Week 45½ in this post)—the Treasury Department and the IRS today issued a 227-page final regulation under the Affordable Care Act's employer shared responsibility (a/k/a "pay-or-play") rules. From the perspective of affected employers (i.e., those with 50 or more full-time and full-time equivalent employees), this new rule is arguably the single most important to be issued under the Act.

A fact sheet issued by the Treasury Department along with the final regulations provides some context for the new rules and alerts readers to some of the highlights, which include:

- Clarifications regarding whether employees of certain types or in certain occupations are considered full-time
- Rules governing seasonal employees and adjunct faculty members
- A delayed effective date for employers with at least 50 but fewer than 100 full-time employees, and
- Additional transition rules.

In the next few weeks we will be parsing this new final regulation, explaining its key provisions, and speculating about how affected employers might comply.

Tags: Affordable Care Act, IRS, pay-or-play rules

The Affordable Care Act—Countdown to Compliance for Employers, Week 46: Looking Ahead to the Group Health Plan Non-Discrimination Rules

Posted By Michael Arnold on February 10th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

By Alden J. Bianchi

A January 18th *New York Times* article (Rules for Equal Coverage by Employers Remain Elusive Under Health Law) reported on the progress, or lack thereof, of the adoption of group health plan non-discrimination regulations under the Affordable Care Act's insurance market reforms. Though originally slated to take effect in plan years beginning after September 23, 2010, the IRS delayed enforcement of the Act's non-discrimination rules as applied to fully-insured group health plans to provide time to write regulations. (For an explanation of the delay, please see our January 13, 2011 advisory.)

There is no requirement that the same group health plan benefits be offered to all employees. That is, employers are generally free to cover some groups of employees and not others and to offer different types of benefits with differing employer contributions. In the case of self-funded plans, there have (since 1978) been rules barring discrimination on the basis of eligibility or benefits in favor of a "prohibited group"—here, highly compensated participants. But before the Act (and except for a brief period of time almost 30 years ago) there were no non-discrimination rules that applied to fully-insured plans.

In choosing to impose non-discrimination rules on fully-insured plans, Congress directed regulators to develop standards "similar to" those that apply to self-funded plans. Congress appears to have assumed that the rules that apply to self-funded plans are well understood and well settled. But that is not the case. Regulations implementing the 1978 law (issued in 1980) have failed to keep pace with group health plan evolution and with changes in the U.S. and global business environment. (For example, in 1980, most plans were fully paid by the employer.) Kathryn Wilber, a lawyer at the American Benefits Council who is quoted in the article said it best, when she characterized the existing rules as "outdated, inadequate and unworkable."

There is another important difference: the rules governing self-funded plans are in the tax code, and violations trigger tax penalties that fall principally on affected prohibited group members. But the Affordable Care Act's non-discrimination rules governing fully-insured plans take the form of amendments to the Public Health Service Act that are incorporated into the tax code and ERISA. The penalty for violating the latter rule is $1,000 per day for each individual with respect to which there is a failure to comply, i.e., each individual who is discriminated against.

The IRS solicited comments on more than a dozen questions relating to the Act's insured plan non-discrimination rules (see Notices 2010-63 and 2011-1). With some license, and glossing over some of the underlying technical issues, the most pressing regulatory challenges are:

(1) Is testing to be based on plan design? Or is it to be based on the "take-up" (i.e., actual enrollment) rate?

One would hope that the regulators prescribe a non-discrimination test that is design-based. A utilization-based test would impose enormous compliance burdens, including quantitative (numerical testing) burdens. The problem is that the rules that apply to self-funded plans appear to impose a utilization-based test, which the regulators may feel that they are bound to follow. If there is one pivotal regulatory issue, this is it.

(2) How does one test a plan that has multiple options?

The Times article put it this way:

"One of the questions facing the I.R.S. is whether an employer violates the law if it offers the same health insurance to all employees but large numbers of low-paid workers turn down the offer and instead obtain coverage from other sources, like a health insurance exchange."

Simply put, the question is: Should a plan that has, say, high, medium and low options, be able to be tested as a single plan—even if (as is likely to be the case) the prohibited group disproportionately elects the "high" option and the rank-and-file group disproportionately elects the "low" and "medium" options? Or should each option be tested as a separate plan? Plans with multiple tiers reflect bona fide, underlying market conditions and life exigencies. So one would hope that the regulators choose the former. The answer to this question is critically important to the operation of private exchanges.

(3) What is the prohibited group?

The Internal Revenue Code has a number of different non-discrimination rules that apply to different types of benefits. The prohibited group definition that applies to self-insured group health plans is different from the prohibited group definition under 401(k) retirement plans, for example. It would greatly simplify administration if the regulators opted to apply the retirement plan definition. But since the definition of what constitutes the prohibited group under the Act's insured group health plan non-discrimination rules is cross-referenced in the law itself, it might prove difficult for the regulators to adopt some other definition.

Irrespective of when these questions are answered, there are a handful of predictions that are either safe or pretty close to safe:

- The focus on non-discrimination in the context of fully-insured plans will likely lead the IRS to circle back and revisit and enforce the rules governing self-insured plans.
- It will no longer be possible for employers to provide group health plan coverage only to highly-paid employees.
- Employers will not be able to provide more generous contribution rates on the part of prohibited group members, nor will employers be able to limit dependent coverage to prohibited group members.

There is no indication that these rules are anywhere near being issued. In the notice announcing the enforcement delay, the IRS promised that there would be ample time to come into compliance once final rules are issued. So it may be that these rules will not take effect until 2016, or even later.

Tags: Affordable Care Act, fully-funded plan, IRS, non-discrimination rules, self-funded plan

The Affordable Care Act—Countdown to Compliance for Employers, Week 47: The Reporting Conundrum

Posted By Michael Arnold on February 3rd, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Affordable Care Act establishes three new, high-level, reporting requirements:

- Code § 6051(a)(14)

Employers must report the cost of coverage under an employer-sponsored group health plan on an employee's Form W-2, Wage and Tax Statement;

- Code § 6055

Entities that offer minimum essential coverage (i.e., health insurance issuers, certain sponsors of self-insured plans, government agencies and other parties that provide health coverage) must report certain information about the coverage to the employee and the IRS; and

- Code § 6056

Applicable large employers must provide detailed information relating to health insurance coverage that they offer.

The W-2 reporting rules have been in effect for a while, and I do not address them in this post. This post instead addresses Code §§ 6055 and 6056, which were originally slated to take effect in 2014, but which were subsequently delayed by one year in IRS Notice 2013-45.

The Treasury Department and IRS issued proposed regulations under both rules on September 30, 2012. (For an explanation of the proposed regulations, please see our October 21, 2013 client advisory. Although garnering far less attention than the Act's pay-or-play rules, the rules under newly added Code §§ 6055 and 6056 should not be overlooked. Both provisions require a good deal of specific information about covered persons and the particular features of the group health plan coverage such persons are offered. Required reports must be furnished to both the government and covered individuals.

- Under Code section 6055, plan sponsors must report to the IRS who is covered by the plans and the months in which they were covered. Plan sponsors must also provide this information to the employees who are enrolled in their plans along with additional contact information for the plan.
- Under Code section 6056, applicable large employers must report to the IRS, and provide to affected full-time employees, information that includes:

(i) The employer's contact information;

(ii) Whether the company offered minimum essential coverage to full-time employees and their dependents;

(iii) The months during which coverage was available;

(iv) The monthly cost to employees for the lowest self-only minimum essential coverage;

(v) The number of full-time employees during each month; and

(vi) Information about each full-time employee and the months they were covered under the plan.

Absent regulatory simplification, the costs of compiling, processing, and distributing the required reports will be substantial. But the regulators are in a difficult position, since they must remain true to the requirements of the law. The proposed regulations do offer some suggestions for simplification. For example:

- Employers might be permitted to report coverage on IRS Form W-2, rather than requiring a separate return under Section 6055 and furnishing separate employee statements. But this approach could be used only for employees employed for the entire calendar year and only if the required contribution for the lowest-cost self-only coverage remains stable for the entire year.
- The W-2 method could also be extended to apply in situations in which the required monthly employee contribution is below a specified threshold (e.g., 9.5% of the FPL) for a single individual, i.e. the individual cannot be eligible for the premium assistance tax credit.
- Employers might be permitted to identify the number of full-time employees, but not report whether a particular employee offered coverage is full-time, if the employer certifies that all employees to whom it did not offer coverage during the calendar year were not full-time.

Industry comments filed in response to the proposed regulations have seized these suggestions to ask for further relief. Some commenters suggested replacing the reporting process with a certification process under which an employer could simply certify that it has made the requisite offer of coverage. Others have asked that information be provided to employees only on request, on the theory that not all employees will need to demonstrate that the employer either failed to offer coverage or that the coverage was either unaffordable or did not constitute minimum value.

While many of the comments submitted in response to the proposed regulations were both thoughtful and practical, many are also difficult to square with the terms of the statute. As a result, the most likely outcome is that the final rules under Code §§ 6055 and 6056 will look a lot like the proposed rules—which look a lot like the statute.

Tags: Affordable Care Act, IRS, IRS Code 6055, IRS Code 6056

The Affordable Care Act—Countdown to Compliance for Employers, Week 48: Obamacare Dodges Another Bullet

Posted By Michael Arnold on January 27th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

A recent Federal Court decision turned back a potentially debilitating challenge to the Affordable Care Act's rules governing premium subsidies. (We discussed the issue in a prior blog post here.) The decision, *Halbig v. Sebelius*, has consequences for large employers, i.e., those that are subject to the Act's employer shared responsibility or "pay-or-play" rules. The dispute giving rise to the claim before the court related to a final IRS regulation—26 C.F.R. § 1.36B-2—authorizing the grant of premium tax credits to low- and moderate-income individuals who qualify for and purchase qualified plan coverage under either a state-run public exchange or a "federally-facilitated" public exchange (i.e., an exchange operated by the Department of Health and Human Services in a state that declines to establish its own public exchange).

The nub of the challenge involved the language of Internal Revenue Code Section 36B, which calculates the amount of the premium tax credit based in part on the premium expense for the health plan. Here's how we explained it previously:

Section 1401 of the Affordable Care Act provides that eligible taxpayers may receive income tax credits for purchase of insurance "through an Exchange established by the State under [Act Section 1311]" (emphasis added). Section 1311 is the provision of the Act that enables the states to establish health insurance exchanges. That provision does not refer to federally-facilitated exchanges. Act Section 1321 provides that if a state does not elect to create an exchange that meets federal requirements, the federal government will "establish and operate" an exchange. This invites the question whether, in a state that fails to create an exchange, there can be any tax credits for insurance bought on a federally run exchange?

The plaintiff in *Halbig* urged the court to hold that individuals in states that fail to establish an exchange will be ineligible for premium tax credits to assist with the purchase of coverage. For employers, such a holding would be good news since assessable payments under the Act's employer shared responsibility provisions are triggered only where one or more employees qualify for a premium tax credit. If no employee is eligible, then there can be no liability for any assessable payments. The court rejected the plaintiff's central claim, however, holding instead that individuals who qualify for and purchase health insurance through public exchanges may receive federal tax credits regardless of whether they buy a plan on a state-established exchange or one that is federally facilitated.

As an aside, one of the claims in the case involved the application of the Anti-Injunction Act, with respect to which the court had to determine whether the employer shared responsibility penalty was a tax. That the court determined that the penalty is a tax is not all that interesting, but its reasoning is priceless:

"The Section 4980H assessment acts like a tax and looks like a tax. The Court therefore embraces a modified version of the "now-infamous 'duck test'": "WHEREAS it looks like a duck, and WHEREAS it walks like a duck, and WHEREAS it quacks like a duck," and WHEREAS it is called a duck by Congress on multiple occasions, "[THE COURT] THEREFORE HOLD[S] that it is a duck."

Tags: Affordable Care Act, IRS

The Affordable Care Act—Countdown to Compliance for Employers, Week 49: Waiting for the Final Code Section 4980H Regulations

Posted By Michael Arnold on January 21st, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

So where are they?

Final regulations implementing the Affordable Care Act's rules governing shared responsibility of employers were widely expected to have "dropped" before the beginning, or perhaps during the first week, of 2014. These regulations implement arguably the most important of the Act's provisions affecting (large) employers. Either the rumor mill is in need of repair, or something has gone off the proverbial rails with the regulators.

An equally compelling question is, once we get final rules, what will they say? The proposed rules invited comments on a wide range of issues, and public comments raised others. Invitations for comments flag issues which the regulators are trying to better understand or on which they are seeking the best option from a number of alternatives. Either way, those seeking to influence the content of the final rules have a strong incentive to engage in the comment process whenever there is an express invitation to do so. It is with respect to these issues that there is the best chance to move the needle.

Set out below are some selected issues on which the Treasury Department and IRS have either asked for comments or for which comments would be helpful (the italicized text below is taken from the preamble to the proposed regulations):

(1) Identifying a predecessor or successor employer for purposes of identifying an applicable large employer

The Treasury Department and the IRS anticipate that rules similar to this provision may form the basis for the rule on identifying a predecessor or successor employer for purposes of the section 4980H applicable large employer determination, and invite comments on whether these employment tax rules are appropriate and whether any modifications of the rules may be necessary. Until further guidance is issued, taxpayers may rely upon a reasonable, good faith interpretation of the statutory provision on predecessor (and successor) employers for purposes of the applicable large employer determination.

The concept of a predecessor or successor employer is important for payroll tax purposes. A successor employer is an employer that (i) acquires substantially all the property used in a trade or business of another person (predecessor) or used in a separate unit of a trade or business of a predecessor, and (ii) immediately after the acquisition, employs one or more people who were employed by the predecessor. The key feature here is business continuity.

It would appear the employers would not be prejudiced if the final regulations draw upon the payroll tax rules when crafting a final rule.

(2) Treatment of employees of educational institutions who work a 9-month academic year as "full-time"

These proposed regulations address these special issues presented by educational institutions by providing an averaging method for employment break periods that generally would result in an employee who works full-time during the active portions of the academic year being treated as a fulltime employee for section 4980H. Comments are invited on any

remaining issues relating to teachers, other educational organization employees, or industries with comparable circumstances.

The preamble to the proposed regulations makes amply clear that employees of educational institutions who work a 9-month academic year may not be treated as seasonal. They instead intend a 9-month academic year to be full-time for Code § 4980H purposes. But this is only the tip of a very large iceberg. One particularly contentious issue is the treatment of adjunct faculty. Other issues include the treatment of coaches, tutors, cafeteria workers, part-time faculty, and even building and grounds personnel. In many of these cases, tracking hours is a challenge. And there is the separate issue of non-employee service providers such as bus drivers employed by commercial third-party firms. These rules are in desperate need of amplification and clarification.

(3) Treatment of workers placed through temporary staffing agencies

[C]omments are invited on whether and, if so, how a special safe harbor or presumption should or could be developed with respect to the variable hour employee classification of the common law employees of temporary staffing agencies that would contain restrictions or safeguards intended to address these concerns while still providing useful guidance for employers and employees in this industry. More generally, further comments are invited on whether special rules for identifying full-time employees or any other issues relating to section 4980H may be necessary in the case of temporary staffing agencies, especially in light of the employment break period rules proposed in these regulations.

The treatment of workers placed through temporary staffing agencies is one of the most difficult issues raised in the proposed regulations. Despite the fact that this topic is discussed at some length in the proposed regulations (and also merits some dedicated examples), it is an area in which the current guidance is difficult to apply. One of the biggest challenges is determining an employee's status as a "variable hour" employee. One suggested approach would ask "(1) whether the employee is replacing an employee who is a full-time employee; and (2) whether the hours of service of ongoing employees in the same or comparable positions actually vary." The problem with this or any facts-and-circumstances test is that the test must be applied worker-by-worker. That sort of determination would pose daunting if not insurmountable logistical challenges, particularly for large commercial staffing firms that issue hundreds of thousands of Form W-2s each year.

(4) Definition of "seasonal employee"

Notice 2012–58 provides that, through at least 2014, employers are permitted to use a reasonable, good faith interpretation of the term "seasonal employee" for purposes of this notice. Notice 2012–58 also requested comments on the definition of ''seasonal worker'' as set forth in section 4980H(c)(2)(B)(ii) for purposes of determining status as an applicable large employer. Specifically, the request for comments asked about the practicability of using different definitions for different purposes (such as for determining status as an applicable large employer versus determining the full-time employee status of a new employee); and whether other, existing legal definitions should be considered in defining a seasonal worker under section 4980H (such as the safe harbor for seasonal employees in the final sentence of § 1.105–11(c)(2)(iii)(C)).

The Act and the proposed regulations use two terms that are often confused: For purposes of establishing an employer's status as an "applicable large employer," certain "seasonal workers" may be excluded. The term "seasonal worker" is defined with reference to a long-standing Department of Labor regulation. For purposes of applying look-back measurement period rules, new "seasonal employees" need not be extended an offer of coverage during their initial measurement period. The term "seasonal employees" is not defined. Instead, employers are currently permitted to use a reasonable, good faith interpretation of the term.

The reference to the final sentence of § 1.105–11(c)(2)(iii)(C) is curious. That provision envisions defining an employee with an annual period of service of less than seven months as a seasonal employee. So the current rule is generally a favorable one for employers. The final rule is likely to be more restrictive.

(5) Extension of the fiscal plan year transition rules to 2015

Commenters on behalf of employers sponsoring plans with plan years other than the calendar year (fiscal year plans) addressed two issues in particular. First, these commenters noted that because the terms and conditions of coverage are difficult to change in the middle of a plan year, application of section 4980H to fiscal year plans as of January 1, 2014

would, in many cases, require compliance with section 4980H for the entire fiscal year plan year beginning in 2013 (the 2013 plan year).

While the proposed regulations did include a fiscal plan year transition rule, the regulators have been silent on whether that rule may be applied in 2015. (We addressed the issue of transition rules in an earlier post).

* * * * *

So what happens if final regulations are not forthcoming? The preamble to the proposed regulations furnishes some help:

"Employers may rely on these proposed regulations for guidance pending the issuance of final regulations or other guidance. Final regulations will be effective as of a date not earlier than the date the final regulations are published in the Federal Register. If and to the extent future guidance is more restrictive than the guidance in these proposed regulations, the future guidance will be applied without retroactive effect and employers will be provided with sufficient time to come into compliance with the final regulations."

While reliance is welcome, it does nothing to resolve the issues set out above, among many others. Employers could muddle through applying the proposed rules. But unlike final regulations, which have the force of law, proposed regulations are not binding, which might be read as license to read Code § 4980H very broadly. Many of the provisions of the proposed rule—e.g., the look-back measurement period—are already modestly aggressive, however. So the proposed rules might not be a bad place to start. (But having final regulations on which to rely is infinitely preferable to trying to apply the current, proposed rules.)

In closing, I invite readers to submit their own suggestions for issues that they would like to see elucidated in final regulations. Those items that generate a strong consensus will be the subject of future blog posts.

Tags: Affordable Care Act, IRS, Section 4980H

The Affordable Care Act—Countdown to Compliance for Employers, Week 50: Wellness Programs, Affordability, and Premium Tax Credits

Posted By Michael Arnold on January 13th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

The Affordable Care Act imposes a series of interrelated requirements on individuals, employers and providers. Individuals must maintain coverage or face the prospect of a tax penalty; carriers must offer and renew coverage. Low- and moderate-income individuals may qualify for premium subsidies to help pay for coverage; but their eligibility for subsidies is affected by the cost and relative generosity of any employer-provided group health coverage otherwise available to them.

"Large" employers (i.e., those with 50 or more full-time and full-time equivalent employees) may face penalties under the Act's rules governing "employer shared responsibility" for failing to offer coverage to their full-time employees. They can, however, reduce or eliminate their exposure to those penalties by offering coverage that is both affordable and sufficiently generous. (For a discussion of rules governing large employers, please see our January 16, 2013 client advisory.)

The Act separately seeks to encourage wellness programs by expanding the exception for wellness programs originally provided for in regulations issued in 2006 under the Health Insurance Portability and Accountability Act (HIPAA). Final three-agency regulations published June 3, 2013, prescribe rules governing the design and operation of wellness programs that offer some sort of reward (e.g., a premium discount) for healthy behavior. In a proposed rule published May 3, 2013, the Treasury Department/IRS issued rules governing, among other things, the impact of wellness programs on group health plan affordability. (We explained those rules in our May 16, 2013 client advisory.)

The regulators previously determined (Treas. Reg. §§ 1.36B(c)(3)(v)(A)(1) and (2) to be exact) that group health plan affordability under the Act's employer shared responsibility rules must in all cases be calculated based on the cost of self-only coverage. The guidance cited above dealing with the impact of wellness programs on group health plan affordability addressed another equally important question, i.e., what premium cost must an employer use to determine whether coverage is affordable? Is it the stated employee premium? Or is it the stated premium cost reduced by the amount of the wellness reward? The answer to this question was much anticipated: from an employer's perspective, taking a wellness discount into account would mean that it would be marginally cheaper for an employer to offer affordable coverage. This means, of course, that the employer could make an offer of affordable coverage—and therefore avoid an excise tax penalty—for less money than it would cost them if they could not take the discount into account. This is not where the regulators landed, at least not entirely.

Under the May 3 proposed regulations, for 2014, affordability is generally determined by assuming that each employee *fails* to satisfy the requirements of a wellness program. This rule applies as well in 2015 and later years, except that affordability is determined by assuming that each employee qualifies for any applicable non-smoker discount.

For example, an employer's workforce includes employees, A, B and C, whose annual W-2 wages are $15,000, $20,000, and $30,000. Assume that the employee premium for self-only coverage is $237.50 per month and the total monthly premium for self-only coverage is $550. Assume further that the employer offers a premium discount of $75 per month for general wellness and $125 per month for smoking cessation. On these facts, ignoring any wellness adjustments and assuming that the employer avails itself of the W-2 safe harbor for affordability determinations, the employer's coverage for Employees A,

B and C, would be affordable if the monthly premiums were $118.75 ($15,000 x 9.5% ÷ 12), $158.33 ($20,000 x 9.5% ÷ 12), and $237.50 ($30,000 x 9.5% ÷ 12), respectively. Here's how affordability breaks down, with and without wellness discounts.

	Employee A	Employee B	Employee C
(1) Employee premium (undiscounted for wellness)	$237.50 **Not Affordable** ($118.75 would be affordable)	$237.50 **Not Affordable** ($158.33 would be affordable)	$237.50 **Affordable**
(2) Employee premium (discounted for wellness—30%)	$162.50 with discount $237.50 without discount **Not Affordable if discount is ignored** ($118.75 would be affordable)	$162.50 with discount $237.50 without discount **Not Affordable if discount is ignored** ($158.33 would be affordable)	$162.50 with discount $237.50 without discount **Affordable**
(3) Employee premium (discounted for non-smoker status—50%)	$112.50 with discount $237.50 without discount **Affordable in 2015 and later years**	$112.50 with discount $237.50 without discount **Affordable in 2015 and later years**	$112.50 with discount $237.50 without discount **Affordable in all years**

Under the general rule, i.e., that affordability is determined by assuming that each employee fails to satisfy the requirements of a wellness program, the coverage in this case is unaffordable for both Employee A and B. So the employer faces a potential excise tax penalty in 2015 and later years if either of these employees qualifies for a premium subsidy (assuming that neither employee qualifies for the non-smoker status discount). In 2014, there is no employer shared responsibility penalty, so the employer does not care. The employee might well care in 2014, however, because whether he or she can qualify for a premium subsidy still hinges on whether the employer coverage that he or she is offered is affordable. If there were a penalty in 2014 (which there would have been but for the one-year delay—explained in our July 10, 2013 client advisory), then the employer would have to "buy-up" in the amount of $103.82 in the case of Employee A and $79.17 for Employee B to make the coverage affordable. If, on the other hand, the employer could assume that each employee satisfied the requirements of a wellness program, then the buy-up would be $47.50 for Employee A and $7.92 for Employee B.

Tags: affordability, Affordable Care Act, FTE, wellness program

The Affordable Care Act—Countdown to Compliance for Employers, Week 51: Speculating about Code Section 4980H Transitional Relief

Posted By Michael Arnold on January 6th, 2014 | Posted in ACA Compliance Series, Affordable Care Act, IRS

Written by Alden J. Bianchi

(Note: This is the first installment of a series of entries that Alden will be posting each week for the next 51 weeks as he counts down to the January 1st, 2015 ACA pay-or-play deadline).

The Affordable Care Act is a massive law that affects a large swath of the U.S. economy. Providers, payers, carriers, individuals, and, yes, employers, are affected, each in different, and in many cases overlapping, ways. For "large" employers, i.e., those with 50 or more full-time and fulltime equivalent employees on average business days during the prior calendar year, the Act's "pay-or-play" rules (a/k/a "employer shared responsibility") are of paramount interest. Though originally slated to take effect January 1, 2014, the pay-or-play rules were postponed for one year, to January 1, 2015 (IRS Notice 2013-45). 2014 will be a critically important year as employers prepare to compliance in 2015. The regulators—principally the IRS, the Department of Labor and the Department of Health and Human Services—must issues the necessary regulations and other guidance necessary to implement the particulars not only of the pay-or-play rules but other provisions of the law that impact the employer- and union-sponsored group health plans.

Proposed regulations issued at the end of 2012 and published in the Federal Register on January 2, 2013 set out a "pay-or-play" framework. (For an explanation of these proposed regulations, please see our client advisory.) The preamble to the proposed regulations granted a series of transitional rules that were intended to assist employers as they endeavor to understand, navigate, and comply. But these transitional rule were all keyed to 2014. With one exception, it's not clear which rules will be extended and which will not. (The IRS as yet to say.) One item of transitional relief—related to the timing of compliance be fiscal year plans—is of particular importance. If this rule is not extended, the compliance will be required in the middle of the plan year commencing in 2014.

Set out below is a summary of the transitional rules together with our speculation on our part as to where the regulators may, should, or will land:

	2014 Transition Relief	2015 Transition Relief
(1)	For purposed of determining an employer's status as an applicable large employer, employers could test any six consecutive months in 2013 as opposed to all of 2013	Unlikely that this rule will be extended. Employers have had ample time to understand this rule and prepare for its application.
(2)	When applying the "look-back measurement method" to determine an employee's status as "variable hour," an employer could factor into anticipated turnover and tenure.	Unlikely that this rule will be extended. The proposed regulations provided this transitional relief reluctantly based on a perceived misunderstanding of the rule in

		prior guidance.
(3)	When applying the "look-back measurement method" to determine an employee's status as "variable hour," an employer that selected twelve month measurement and twelve month stability periods could shorten the 2013 measurement period to no less than six months, beginning July 1, 2013.	Unlikely that this rule will be extended. Employers have had ample time to understand this rule and prepare for its application.
(4)	Any employer failing to offer dependent coverage during 2014 could avoid the § 4980H(a) employer mandate by taking steps during its plan year that begins in 2014 toward offering of coverage to full-time employees and their *dependents*.	Unlikely that this rule will be extended. Employers have had ample time to understand this rule and prepare for its application.
(5)	Employers with fiscal years plans that previously offered coverage to a at least 33% of all employees (full-time and part-time) or actually covered 25% of all employees limit compliance to coverage months commencing with the 2014 fiscal year provided the coverage was unchanged from December 27, 2012.	It is hoped that this relief or some form of it survives. The plight of fiscal year plans has not changed with the passage of 12 months. Compliance with the Act's employer shared responsibility rules will still start mid-year. Failure to extend the rule would mean that an employer would either need to (i) comply sooner than the law requires or (ii) change their group health plan mid-year.
(6)	An employer could amend its fiscal year cafeteria plans to permit certain salary reduction elections to be made during 2013 so that employees could either (i) drop employer-provided coverage and instead obtain coverage through a public exchange, or (ii) elect to enroll in employer-provided coverage in order to avoid the individual mandate tax.	In recently issued guidance issued (IRS Notice 2013-71, Section VI.B; this rule was been extended.
(7)	An employer is treated as making an offer of coverage by virtue of contributing to a collectively bargained multiemployer plan, provided that the plan covers dependents, is affordable, and provides minimum value.	*Some*relief is necessary for employers that contribute to collectively bargained multiemployer plans. And while this rule is decried as "transitional" in nature, it more structural than transitional. If the regulators are not prepared to announce a permanent rule any time soon, then this relied should be extended.

We expect that these relief transitional issues will be addressed in final regulations or other guidance, which we hope to see sooner rather than later.

Tags: Affordable Care Act, IRS, Section 4980H