The Top 10 Health Plan Compliance Issues for 2015

Ashley Gillihan, Esq.
ashley.gillihan@alston.com
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Top 10 Compliance Issues

1. Are non-network plans permissible?
2. Are “skinny” plans legal?
3. Can employers give employees after-tax dollars to use for health insurance in the individual market (including but not limited to the Exchange)?
4. Are health plans required to cover same sex spouses?
5. Which benefits are included in the Cadillac tax calculation?
Top 10 Compliance Issues

6. Can employers give “lasered” (aka unhealthy) employees/dependents additional compensation to opt out of the health plan?

7. Does providing an cash “opt out” option affect the employer’s affordability determination under 4980H?

8. When are employers required to report under Code Sections 6055 and 6056?

9. When are Health FSAs considered to be an excepted benefit?

10. How does recent EEOC guidance impact wellness programs?

#1: Are non-network plans impermissible?

• Generally speaking, non-network plans are permissible.

• Potential legal issues relate to the application of OOP max to balance billed amounts.

• All non-grandfathered plans are subject to a maximum on the annual amount paid by covered individuals for covered essential health benefits (i.e. cost share)?

  • $6,600 for self-only coverage (2015)

  • $13,200 for other than self-only coverage (2015)
#1: Are non-network plans impermissible?

- Expenses that must count towards the OOP maximum:
  - Deductibles, coinsurance, copayments or similar charges on covered essential health benefits
  - “any other expenditure required of an individual which is a [Code Section 213(d) expense other than premiums] with respect to the EHB covered under the plan”

- Expenses that are excluded from OOP maximum:
  - Out of network expenses (if the plan has a “network”)
  - Expenses treated as out of network under RBP guidelines
  - Non-covered expenses
  - Non-essential health benefits
  - Premiums
  - “balance billing amounts for non-network providers” (see Section 1302(c)(3); Q/A 5 from FAQ XVIII)

#1: Are non-network plans impermissible?

- Arguments for exclusion:
  - 1302(c)(3) (but see below)
  - Q/A 5 from FAQ XVIII
  - Balance billed amounts not “covered”

- Arguments against exclusion:
  - 2707 doesn’t refer to 1302(c)(3)
  - Exclusion is an end around the OOP maximum rules
  - Informal comments from agency officials

- Do RBP guidelines apply?
#2: Are skinny plans legal?

• What is a “skinny” plan?
  • Plans that purport to provide minimum essential coverage but limit coverage?
    • Plans that provider only preventive care
    • Plans that do not provide one or more major medical benefits (e.g. physician services, hospitalization, etc.)?
    • Others?

• What is minimum essential coverage?
  • A group health plan that provides other than excepted benefits

• Are they legal?
  • Generally, they are legal if self insured AND they otherwise comply with ACA
    • Self insured benefits do not have to offer essential health benefits
    • The only “coverage” requirement under the ACA relates to recommended preventive care services and that applies only to non-grandfathered plans
#2: Are skinny plans legal?

- Are they practical?
  - According to Notice 2014-69/recent regulations, such plans cannot qualify as “minimum value”
    - If not minimum value, then cannot be used by ALEs to avoid 4980H(b) tax (aka the Taxhammer Tax)
    - But if they qualify as MEC, ALEs can avoid 4980H(a) tax (aka the Sledgehammer Tax)
    - If MEC, then can help individuals avoid individual mandate tax

#3: Can employers offer after-tax dollars to purchase individual market coverage?

- Notice 2013-54 created a new type of health plan?
  - “employer payment plan”
- What is an “employer payment plan”?
  - ANY arrangement that pays or reimburses an employee on a pre-tax basis for his or her premiums for individual market, major medical coverage?
  - ALSO includes any arrangements that attempt to do the same thing with after-tax dollars?
#3: Can employers offer after-tax dollars to purchase individual market coverage?

- So what can/can’t you do?
  - You cannot provide employees after-tax dollars the receipt of which is conditioned on purchasing individual market coverage
  - You cannot agree to forward payroll deductions to a limited selection of carriers
  - You CAN give employees additional taxable compensation that they can use for any reason they deem suitable

#4: Are health plans required to cover same sex spouses?

- Windsor and subsequent related IRS guidance simply requires federal law that references/defines spouse to include same sex spouse if marriage entered into legally
- Windsor did not add a new federal requirement to cover same sex spouses!!!!
  - If ERISA or some other federal required a health plan to cover a “spouse”, then the impact of Windsor would have been that the legal requirement to offer coverage to a spouse included a requirement to offer coverage to a same sex spouse.
  - No such specific requirement exists.
- Are there any federal laws that might indirectly require coverage?
  - Title VII?
- What about state laws?
  - E.g. anti-discrimination laws
  - Preempted by ERISA?
- What impact will a decision by Supremes to overturn state bans on same sex marriage have on benefit plan design?
#5: What benefits are included in the Cadillac Tax calculation?

- The Affordable Care Act added Internal Revenue Code Section 4980I which creates a new nondeductible 40% excise tax starting in 2018 on the value of “applicable employer-sponsored coverage” in excess of statutory thresholds

- What is its purpose?
  - Ostensibly to prevent over consumption due to tax subsidies
    - Too many colonoscopies?
  - Legislative history
    - Stop tax “leakage” from employee exclusion for employer provided health care
  - Revenue raiser to pay for ACA (such as individual premium subsidies)

- Expected to Impact 48% (or more) of Employers in 2018

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#5: What benefits are included in the Cadillac Tax calculation?

- What are thresholds?
  - 10,200 for self only
  - 27,500 for other than self-only

- Union plans
  - All coverage subject to 27,500

- Adjustments made for:
  - High risk professions
  - Retirees
  - Age/gender
#5: What benefits are included in the Cadillac Tax calculation?

- What is applicable employer sponsored coverage (according to statute):
  - The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee except:
    - Fully insured vision
    - Fully insured dental insurance,
    - Accident and disability insurance,
    - Long-term care insurance, and
    - After-tax funded hospital indemnity and/or specified disease coverage
  - Includes non-elective and salary reduction contributions to a health FSA
  - Employer contributions (including salary reductions) to an HSA (IRS Notice 2015-16)

- Recent guidance suggests the following:
  - Dental/vision that qualifies as an excepted benefit would not be included
  - EAP would not be included
  - Onsite health clinics that provide de-minimis benefits would not be included

- Comments requested on how coverage will be valued?
  - Different levels of other than self only
  - HRA coverage a big issue
6. Can employers give “lasered” (aka unhealthy) employees/dependents additional compensation to opt out of the health plan?

• **NO!!!!!!!**

• Typical design: Employer identifies unhealthy individuals and offers them additional dollars to opt out of coverage

• At first glance this appears to discriminate in favor of the unhealthy individual

• Agencies believe that such an offer discriminates AGAINST unhealthy
  • The choice between additional cash or coverage makes health insurance premium higher (equal to the opt out amount)

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#7: Does a cash “opt out” option affect an employer’s affordability determination under 4980H?

• Apparently not at the moment but ...........

• Based on agency guidance discussed in #6 and informal comments with IRS, offering the employees a choice between coverage or additional cash to opt out could increase the premium for affordability purposes

• IRS has not specifically addressed cash options yet

• Example: Premium for self only is typically $90 per month (below the FPL standard and “affordable” for purposes of 4980H). Employees who choose to forgo medical coverage under the plan receive $20 per month in additional taxable compensation. IRS might ultimately view the premium amount to be $110 (not $90) for purposes of affordability
#8: When are employers required to report under Code Sections 6055 and 6056?

• Two different code sections that require reporting:
  • Code Section 6055: coverage providers are required to identify who had MEC at least 1 day each month
  • Code Section 6056: ALE members are required to identify offers of coverage made to full-time employees

• When are employers required to report?

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• Why?
  • To give IRS and Taxpayers information necessary to administer the individual mandate!!!!!
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- **Who?**
  - "Coverage Provider"
    - If plan is fully insured, carrier is responsible for reporting
    - If plan is self-insured, “plan sponsor” reports
      - Each member of a controlled group whose employees participate in a health plan constitute a separate and independent plan sponsor
      - Special reporting rule if not an ALE
      - Each employer participating in a MEWA constitutes a separate and independent plan sponsor
    - What if MEWA is maintained by “bona fide association”?
      - If plan is multi-employer plan, joint board of trustees, association, or committee who maintains the plan
      - If a plan is a union plan (but not a multi-employer plan), the employee organization is the plan sponsor

- **Third Party may file on behalf of coverage provider BUT coverage provider remains liable**
  - What steps must third party take to file on behalf of a coverage provider?

- Special rule for governmental entities that allows governmental entity to designate another, related governmental entity as the party responsible for filing (to the extent the designated entity agrees in writing)
• What?
  • Identify all individuals covered under a plan providing minimum essential coverage at least one day of any month DURING THE CALENDAR YEAR
  • Includes employees, retirees, dependents, independent contractors, qualified beneficiaries, “alternate recipients” covered pursuant to a QMCSO, non-employee board members
  • 6724 Solicitation of Dependent’s SSN
    • The “3 requests” requirement
      • When the relationship begins
      • By December 31 of the year in which the relationship begins
      • By December 31 of the next year
    • Use DOB if unable to receive the dependent’s SSN

• What?
  • Plan year not relevant; all reporting is done on a calendar year basis
  • No description of coverage needed
    • Only reporting for those covered under a plan that qualifies as MEC generally
  • What is MEC?
    • Any group health plan that provides other than excepted benefits
      • Affordability not relevant
      • Minimum value not relevant
    • No reporting for supplemental coverage
      • Secondary to Medicare/Tricare
      • Coverage supplemental to major medical of same plan sponsor
        • Reporting required if supplemental self-insured and major medical fully insured
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- **How?**
  - Generally, coverage providers will use 1094/1095-B series to report MEC enrollments to IRS and “responsible individuals”
  - HOWEVER, if plan is *self funded* and sponsored/maintained by *applicable large employer member*, then . . . . .
    - MUST use 1094/1095-C series to report any individual who was an employee in any month of the calendar year, and his/her dependents, who were covered under the self-insured MEC plan at least one day of any month in the calendar year
    - *May but not required* to use C-Series to report individuals covered under self-insured MEC plan who were not employees *at any time during the year*
    - If C-series not used for non-employee covered individuals, then use B-Series.

- **Send to last known address of “responsible individual”**
  - Employee
  - Former employee
  - Parent
    - Alternate recipient covered pursuant to QMCSO
    - Other individual who enrolls themself and others
      - Qualified beneficiary ex-spouse?
  - First class mail
  - Electronic if advance consent provided by responsible individual
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• When?
  • In the year following the calendar year being reported

  • To IRS:
    • March 31 if filing electronically
    • February 28 if filing paper forms

  • To primary responsible individual: January 31

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• Why?
  • So IRS can administer employer shared responsibility requirements

  • So IRS and taxpayers can administer the premium tax credit/subsidy under Code Section 36B

  • Although any employee can qualify for credit/subsidy, no reporting for credit/subsidy related reporting required for other than full-time employees
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• Who?
  • Each applicable large employer member
  • Each member of the controlled group of corporations ("ALE member") that constitute an applicable large employer is independently responsible for reporting
  • Third Party may file on behalf of ALE member BUT ALE member remains liable
    • Special rule for governmental entities (same rule as applicable under 6055)

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• What?
  • Identify all employees who were full-time employees (as defined by 4980H) at least one full month during the year
  • Identify the coverage that was offered, if any, during months that the employee was a full-time employee was made during the months that the employee was full-time employee
  • If coverage was not offered for an entire month, identify whether any exceptions to excise tax apply
    • E.g. employee not employed during that month
    • E.g. employee part time during the month
    • E.g. employee in limited non-assessment period
  • If coverage offered during a month, indicate whether coverage was affordable or not in such month
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• What?
  • It doesn’t matter for 6056 purposes whether coverage is fully-insured or self-insured, or even whether coverage is offered at all.
  • If an employer is an ALE member, and the employer has at least one employee who qualified as a 4980H full-time employee, 6056 REPORTING IS REQUIRED!!!!!!

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• How?
  • Use 1094/1095-C series to report to IRS and full-time employees.
  • Send to last known address of full-time employee
    • First class mail
    • Electronic if advance consent provided by responsible individual
  • Relief for full-time employee reporting for:
    • Full-time employees who received a “Qualifying Offer” for all 12 months
      • Relief not applicable with respect to such full-time employees who actually enrolled in a self-insured plan
    • Employers subject to Qualifying Offer Method Transition Relief (only for 2015)
    • Relief for reporting to IRS and full-time employees under 98% offer method
6056

• When?
  • In the year following the calendar year being reported
  • To IRS:
    • March 31 if filing electronically
    • February 28 if filing paper forms
  • To full-time employee: January 31

Key Clarifications in Instructions

• Clarity on 6055 reporting by ALE members for individuals who are not employees at any time during calendar year but are enrolled in self-insured plan
  • May use C-series form to report non-employee covered individuals
  • Must use B-series if no SSSN
• Reporting relief for full-time employees who receive a qualifying offer for all 12 months not available if actually enrolled in a self insured plan.
• Offer to spouse conditioned on reasonable objective restrictions still considered an offer even if spouse doesn’t meet condition
  • E.g. spouse is eligible to enroll only if not eligible for other employer coverage is “reasonable” objective restriction
• Clarification regarding supplemental coverage (e.g. HRAs)
• Codes for multi-employer transition relief
• Reporting for COBRA offers
  • Special rule for COBRA to active employees (e.g. full-time to part-time or leave of absence)
  • Special rule for COBRA to terminated employees
#9: When are Health FSAs excepted benefits?

• Why do we care?
  
  • Health FSA will fail to satisfy the requirement to provide all recommended preventive care services without cost share unless it is an excepted benefit (see Notice 2013-54)
  
  • PCORI fees may apply

• 2 requirements must be satisfied:
  
  • #1: Maximum benefit may not exceed 2x the employee’s salary reduction or, if greater, the employee’s salary reduction plus $500
  
  • If employer provides non-cashable Health FSA credits (e.g. wellness program) in excess of $500 without regard to whether employee contributes or not, then Health FSA will not satisfy this condition
#9: When are Health FSAs excepted benefits?

• #2: employees eligible for Health FSA must be eligible for major medical coverage offered by the same employer who sponsors Health FSA

• Not an integration standard

• Problem area: Employer doesn’t offer coverage to part-time employees but allows part-time employees to contribute to health FSA

#10: How do recent EEOC regulations impact wellness programs?

• Must to people’s dismay, the ADA actually impacts wellness programs

• Disability not an issue!!!
Americans With Disabilities Act (ADA)

**Americans With Disabilities Act**
- **Coverage:** 15 or more employees
- **Substantive Provisions:**
  - Non-discrimination / Accommodation
  - Restrictions on Medical Examinations
  - Confidentiality of Medical Information

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**Americans With Disabilities Act**

- **Non-Discrimination/Accommodation**
  - Provisions only apply to "disabled" individuals
    - **Definition:** Physical or mental impairment that substantially limits one or more major life activities.
  - Most behaviors targeted by wellness programs do not rise to the level of a "disability" under the ADA
    - Smoking – No
    - Weight – Maybe
    - Alcohol Consumption – Yes
  - **Beware:** "Regarded As" Disabled Claims
Americans With Disabilities Act

• **Rules for Medical Examinations and Inquiries:**
  - **Applicants:**
    - Pre-Offer: No examinations or inquiries allowed
    - Post-Offer: Examinations permitted, but must apply to all employees
  - **Employees:** Must be "job-related and consistent with business necessity"
    - Applies to all employees (whether disabled or not).
    - "Job-related" = Ability to perform essential job functions

Americans With Disabilities Act

• **Voluntary Wellness Program Exception:**
  - **Statute:** "A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."
  - **Regulation:** Prior to this spring, EEOC had not promulgated any regulation about meaning of "voluntary"—or how incentives fit in.
  - **Prior Enforcement Guidance:** "Voluntary" means no penalty can be imposed for not participating; anything other than "de minimis" incentive is prohibited.
Case Law Prior to New Regulations

• **EEOC v. Honeywell**: EEOC contends the financial "penalties" for those who do not complete biometric tests include: (1) a $500 surcharge for the employee; (2) a $1,000 tobacco surcharge for the employee; (3) a $1,000 tobacco surcharge if the employee's spouse refused to complete the tests; and (4) non-receipt of a Health Savings Account (HSA) contribution up to $1,500.

• **EEOC v. Orion Energy Systems, Inc., (E.D. Wis., 8/20/14)** – loss of employer subsidy plus $50 "surcharge" if no biometrics (incl blood work).

• **EEOC v. Flambeau, Inc.,(W.D. Wis., 9/30/14)** – loss of coverage if no biometrics (incl blood work).

• **Seff v. Broward County, 691 F. 3d 1221 (11th Cir. 2012)**
  - ADA's bona-fide group health plan safe harbor provision allowed wellness incentives (no review of "voluntariness" issue).

Proposed EEO Regulations

• Programs with disability-related inquiries/medical exams must be "voluntary:"
  - No exclusion from health plan (or ANY plan options) or limiting coverage based on refusal to answer disability based inquiry
  - No requiring participation
  - No retaliation for not participating
Proposed EEO Regulations

If wellness program makes disability related inquiries/requires medical exam and is part of group health plan, then “voluntary” element also includes:

- 30% Limit on all incentive based wellness programs that are part of group health plan and make disability related inquiries/require medical exam
  - Based on total cost of self only (no rule for family members)
  - Applies to HIPAA’s participation based program
  - Does not apply to tobacco cessation if tobacco use determined through certification
  - If part of a group health plan, must provide specific notice of programs terms

Other rules applicable to all wellness programs:

- Accommodation applies to ALL wellness programs (absent undue hardship)
  - Regs contemplate waivers if under treatment plan
- Heightened confidentiality requirements
  - Can only receive aggregate, unidentified info unless identifiable info is necessary for plan administrative purposes
  - Basically the same as HIPAA requirements (if part of group health plan)
  - Must be “reasonably designed to promote health and prevent disease”
  - Can’t be overly burdensome, a subterfuge for violating the ADA or highly suspect in method chosen