Morgan Lewis

CONSUMER-DRIVEN HEALTHCARE POST-ACA

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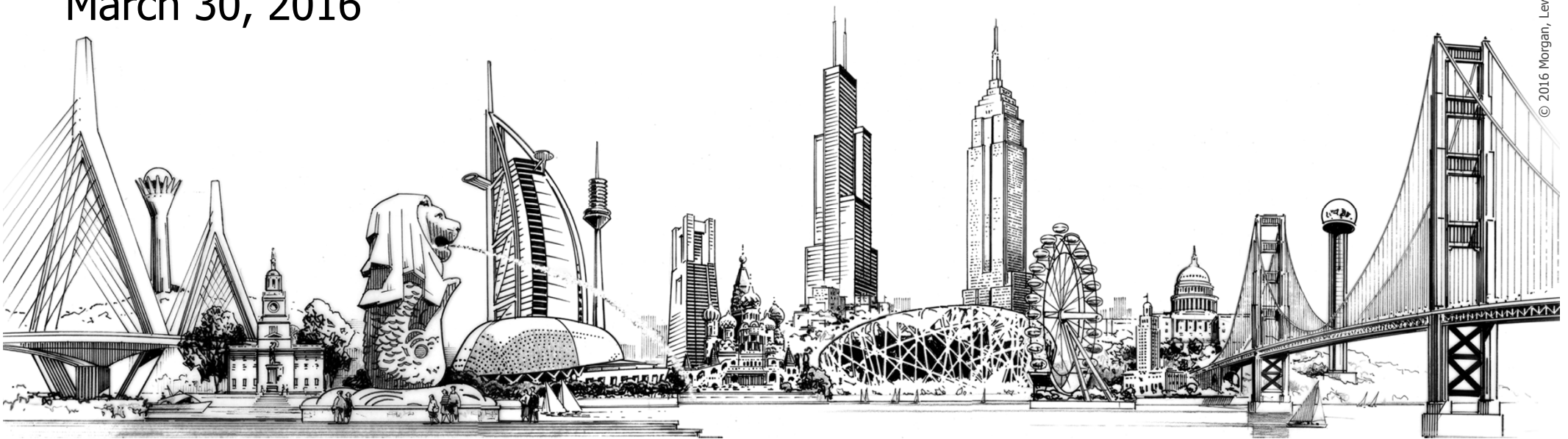

CONSUMER-DRIVEN HEALTHCARE POST-ACA

OVERVIEW

Overview

- Started with ERISA
  - What is subject to reporting and disclosure?
- Gained momentum with COBRA, HIPAA, etc.
  - When is a benefit a health plan subject to design and operational requirements?
- Since 2010, we've seen a web of ACA rules pop up:
  - What is a health plan?
    - Because health plans are subject to ACA mandates
  - When is coverage affordable?
    - Both for individual and employer mandate purposes
  - What satisfies the individual and employer mandate?
- This web challenges existing design and operational realities across health plans—particularly with consumer-driven arrangements

Overview

- Great fear among regulators that clever employers will avoid ACA mandates, prevent employees from receiving subsidized Exchange coverage, and sidestep Shared Responsibility requirements
- Why now?
  - Starting 2017 design discussions
  - Some current design features are (or will be) impermissible by 2017—or at least under heavy regulatory and FAQ fire
  - Can't count on a Republican House, Senate, or Presidency next year

Overview

- Lots of unexpected and counterintuitive wrinkles under the last few years of guidance
- Need to examine:
  - HRAs
  - Health FSAs
  - Pricing approaches
  - Credits
  - Opt-out payments
  - Reimbursement practices
- Failing to meet ACA mandates can subject an employer to excise tax under Code section 4980D of $100 per pay, per participant
  - General cap of $500,000 per year per entity
    - Note, for many, FAR more expensive than the Shared Responsibility excise tax—and applies regardless of employer size . . .

HRA DESIGN

HRA Design

- HRAs are account-based unsecured promises to pay employee health expenses
  - Similar to a HFSA, but no employee contributions and unused funds can rollover from year to year
  - Contain a fixed $ promise
    - Absent careful design, violate ACA limits on annual $
  - Represent MEC for ACA employer mandate and reporting purposes
  - Constitute a health plan for ACA mandate purposes
    - Absent careful design, violates ACA mandates by, among other things, failing to offer preventive benefits

HRA Design

- In order to avoid ACA problems, HRAs must be integrated with an ACA-compliant group health plan
  - In other words, stand-alone HRAs are dead for employees
    - Still some room for stand-alone designs in the context of retiree-only arrangements such as post-65 "Exchange" plans that contain individual Medicare supplemental policies and HRAs to help pay for individual premiums and out-of-pocket expenses
  - To be "integrated", HRAs must:
    - Require enrollment in both HRA and the group health plan
      - Be careful with "family" HRA but self-only health coverage
  - Cannot be used to purchase individual coverage
  - Could limit HRAs to only excepted benefits (vision, dental, etc.)
  - Can continue to use HRAs once participation in underlying health plan ends
  - Limits must be imposed by terms—not merely by operation

HRA Design

- Unclear how far these HRA concerns go:
  - Can employees accrue HRA balances for retiree health expenses if they are not enrolled in an active employee health plan?
  - Do VEBAs that function as retiree medical savings vehicles for employees work if they are not enrolled in an active employee health plan?
- See also HRA credit discussion later in material

HFSA DESIGN

HFSA Design

- HFSAs are only exempt from ACA mandates if they are a HIPAA excepted benefit:
  - Offered in conjunction with a health plan
    - So no stand-alone HFSAs
  - Limit true employer contributions to $500
    - Or employer matching contributions at $-for-$ rate
- Does this restrictive HIPAA rule still make sense given the ACA-mandated annual $2,500 maximum?
- See also HFSA credit discussion later in material

PRICING APPROACHES, CREDITS, AND OPT-OUT PAYMENTS: SHARED RESPONSIBILITY CONCERNS

Pricing Approaches

- Employers with 50 or more FTEs are subject to ACA Shared Responsibility excise tax exposure if health coverage is not (among other things):
  - Minimum essential coverage
  - Minimum value
  - Affordable (9.66% of household income for 2016, with 3 optional safe harbor approaches)
    - Measured by least expensive single employee health coverage
    - Employee price tags only part of the equation—must also consider wellness programs, credits, opt-out payments
      - As a consequence, ACA Shared Responsibility exposure can be created by pricing approaches that tip coverage into unaffordability
        - Nothing prevents using these approaches, but be careful that their Shared Responsibility and Form 1095-C reporting consequences are clearly understood!

Pricing Approaches

- Pricing can be straightforward
  - Employee premium of $x
  - Employer subsidy is the difference (and unstated) balance of the full cost of the coverage (basically, the remainder of the COBRA premium)
  - Depicted simply as flat $ amount per month for the least expensive single employee coverage
    - This flat $ amount is used, along with one of three permissible safe harbors, to determine whether the coverage is affordable for Shared Responsibility purposes and also reported on Line 15 of Form 1095-C
      - Example: least expensive single employee coverage equals $92 per month

Pricing Approaches

- Pricing can be more complicated
  - Full cost of least expensive single employee coverage = $500 per month
  - Employer credit of $408 per month
  - Employee premium = $92
- The objective of this more complicated approach can be to:
  1. Highlight the level of employer support for the cost of coverage (the major principle underlying consumer-driven design)
     - May also represent employer HRA/HFSA/HSA credits or contributions
  2. Allow "spending" the credit on other tax-free benefits (after all, employees know best whether they need health coverage or more highly prize other benefits)
  3. Permit extracting the employer credit in the form of cash or taxable benefits
- These approaches directly impact affordability for Shared Responsibility purposes

Credits

- The days of "full flex" plans with realistic (read COBRA-like) price tags and large pools of credits are long since past
  - Or are they?
  - Consider "consumer driven" designs and private exchanges for post-65 and pre-65 retirees, pricing structures for private exchanges for employees, and HRA/HFSA/HSA credits related to high-deductible health plans……
    - Apart from post-65 retiree arrangements, realistic price tags and fully priced employer credits are still in the minority

Credits

- If a flex credit is treated as a "health flex contribution", then it makes the least expensive single employee price tag cheaper
- A health flex contribution is a sum that:
  - Cannot be received as a taxable benefit
  - May be used to purchase MEC
  - Can only be used for premiums or the HFSA
    - Example: $130 monthly premium, $500 annual employer flex credit = $88 cost, even if all of the flex credit goes to HFSA
- Note that this is not a traditional credit—it cannot be used within the broader confines of a cafeteria plan for life insurance or a dependent care FSA and cannot be taken as taxable $
- Clearly not a traditional "full flex" plan design
  - More like a mere informational approach/limited by HFSA rules (see above)

Credits

- A related design may be a $130 monthly price tag with a $500 annual contribution to an HRA (HRA $ cannot be driven by employee elections)
  - HRA contributions also impact affordability (and, hence, reporting) if amounts can be used for plan premiums
    - Treated as made ratably on a monthly basis
    - Practically, makes underlying least expensive single employee coverage more "affordable" for Shared Responsibility purposes
    - Results in the same monthly $88 cost as above
- HSA $ does not impact affordability since HSA balances cannot (generally) be used for premiums
- Limited 2016 transition relief for plans that do not satisfy health flex contribution rules
  - Adopted on or before 12/16/2015 and no "substantial increase" in credits after 12/16/2015

Opt-Out Payments

- A simpler variant of a full flex plan with credits is to provide employees with taxable $ if they opt out of health plan coverage
  - Example: $88 monthly premium, $500 annual opt-out credit = $130 cost
    - Not "affordable" under the federal poverty line safe harbor……
    - Practically, make the least expensive single employee premium MORE expensive for affordability purposes
- Treasury will propose generally prospective regulations
  - Anticipate also addressing conditional opt-out credits such as proof of other coverage
  - Anticipate that regulations WILL apply to any opt-out credits adopted after 12/16/2015
    - Requires employers to report opt-out credits NOW if adopted after 12/16/2015 and there are no conditions on the opt-out credit

REIMBURSEMENT PRACTICES

Consumer-Driven Healthcare Post-ACA

- Reimbursement practices
  - Not uncommon to reimburse individuals for the cost of individual health coverage
  - Historically pre-tax or after-tax
    - Long-standing ERISA considerations
  - ACA guidance (most recently IRS Notice 2015-87) treats these "employer payment plans" as subject to ACA mandates
    - Although pre-tax reimbursement is still tax effective!
  - Such employer payment plans will not satisfy ACA mandates
  - Consequence:
    - Section 4980D excise tax of $100 per day per person; cap of $500,000 per year per entity
      - Note, for many, FAR more expensive than the Shared Responsibility excise tax—and applies regardless of employer size . . .

Reimbursement Practices

- Generally treated as an "employer payment plan" and prohibited
  - Even if a cafeteria plan pays for individual premiums on a pre-tax basis

Consumer-Driven Healthcare Post-ACA

- What is left?
  - Retiree-only plans (technically, less than two current employees)
  - Excepted benefits
    - Dental
    - Vision
    - Fixed indemnity, etc.
  - Reimburse COBRA premiums?
  - Merely increase taxable compensation, as long as there is no direct link to insurance premiums or even receipt of other coverage

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QUESTIONS?

Biography

Andy R. Anderson
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Leader of Morgan Lewis's health and welfare task force, Andy R. Anderson is often recognized for his work in counseling clients on employer, individual, and insurer issues created by the Affordable Care Act, and regulatory compliance issues in relation to the Internal Revenue Code, ERISA, COBRA, HIPAA, and Mental Health Parity. Tax-exempt organizations and Fortune 500 companies turn to Andy for handling their benefit plans, and legal review surrounding welfare benefit plans, government self-correction programs, cafeteria plans, and VEBAs.

Biography

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Sage Fattahian counsels clients on all aspects of health and welfare plans. She works with clients to comply with the complicated, shifting requirements under the Internal Revenue Code, ERISA, ACA, COBRA, and HIPAA. She also guides clients through the entire process of preparing and reviewing plan documents and related materials, as well as reviewing and negotiating services agreements with third parties.

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