Labor and Employment Alert: Agency Guidance on Health Plan Strategies that Don't Work as Advertised and Other Employee Benefit News

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"No-hospitalization" plans are not minimum value

Starting in 2015, a large employer will be subject to pay or play penalties if it fails to offer affordable health coverage that provides at least minimum value to its full-time employees. A health plan provides "minimum value" if it is designed to pay at least 60% of the total cost of medical services for a standard population. This is generally equivalent to a bronze level plan sold in the public health insurance Exchange.

Before this guidance, there were two options for demonstrating that a health plan provides at least minimum value coverage: (1) the HHS Minimum Value Calculator; or (2) an actuarial certification. It turns out that the HHS Minimum Value Calculator assigns a 60% minimum value to plans with comprehensive outpatient coverage but no inpatient coverage (no-hospitalization plans). A number of employers (especially in the staffing industry) embraced the no-hospitalization plans as a low-cost way to offer an affordable, minimum value plan and avoid pay or play penalties. However, the IRS and HHS do not like that strategy (which blocks employees from accessing subsidies to buy insurance in the Exchange) so they are changing the rules for determining minimum value.

According to IRS Notice 2014-69 (November 4, 2014), a plan without "substantial coverage" of both physician services and inpatient services cannot rely on the HHS Minimum Value Calculator. HHS and the IRS are working on new regulations. We expect that those regulations will explain what constitutes "substantial coverage" of inpatient services.

Given the timing of Notice 2014-69 (after many employers finalized their arrangements for 2015), the IRS is allowing a one-year transition for employers that have – in reliance on the results of the HHS Minimum Value Calculator – entered into a binding written commitment to adopt a no-hospitalization plan (or that have begun enrolling employees in a no-hospitalization plan) prior to November 4,

2014. Under the transition rule, the coverage will be treated as if it had been minimum value for purposes of avoiding the employer pay or play penalties, but the coverage will not prevent an employee's access to subsidies to buy insurance in the Exchange. An employer affected by this transition rule will need to notify employees that the employee may be able to access subsidies to buy insurance in the Exchange despite the offer of coverage under the employer's no-hospitalization plan.

No employer payments for individual health insurance

Newly published DOL FAQs XXII (November 6, 2014) clearly state that an employer cannot reimburse an employee for individual health insurance premiums even if the employer treats the reimbursement as taxable. The reimbursements are treated as an employer payment plan regardless of whether the employer treats the payments as non-taxable or taxable. An employer payment plan violates the ACA prohibition on dollar limits and could subject the plan sponsor to penalties of $100 per day ($36,500 per year) per affected participant. Any arrangement where employer payments are tied to an employee's enrollment in individual health insurance should be reevaluated in light of these FAQs.

Employers can't offer high-claims employees extra cash to waive health coverage

DOL FAQs XXII also address an arrangement whereby an employer offers payments to employees with expected high health claims if and only if they waive the employer's health coverage. These payments are only available to the employees with expected high health claims. FAQ-3 explains that such an arrangement "effectively increases the premium or contribution the employer's plan requires the employee to pay for coverage under the plan because, unlike other similarly situated individuals, the high-claims-risk employee must accept the cost of forgoing the cash in order to elect plan coverage." Because the high-claims employee would need to give up more taxable pay (i.e., the special payments plus the normal employee contributions) in order to enroll in the employer's health plan than similarly-situated healthy employees, the arrangement discriminates on the basis of health status. As with violations of other mandates, this can subject the plan sponsor to penalties of $100 per day ($36,500 per year) per affected participant.

The IRS and DOL plan to issue regulations to elaborate on permissible benign discrimination in favor of plan participants with adverse health conditions (such as enhanced health benefits or lower cost sharing). Permissible benign discrimination will not include techniques intended to discourage participation in or induce waiver of the employer's health coverage.

Although not addressed in the FAQs, singling out employees on the basis of adverse health status (or because they have family members with adverse health status) also raises employment law and HIPAA privacy issues.

OTHER EMPLOYEE BENEFIT NEWS

Typical wellness program survives the first round with the EEOC

In our October 30, 2014 client alert, Warning for Wellness Programs – EEOC Sues Over Typical Wellness Program, we told you about the EEOC's characterization of the wellness program sponsored by Honeywell International, Inc. as a violation of the Americans with Disabilities Act (ADA) and the Genetic Information and Nondiscrimination Act (GINA) due to the fairly typical financial incentives for participation (and the surcharges for declining to participate). We are pleased to report that, on November 3, 2014, the District Court of Minnesota denied the EEOC's request for a preliminary injunction. However, this is not a resolution of the EEOC's objections to Honeywell's wellness program. As stated in the Court order, "[s]hould this matter proceed on the merits, the Court will have the opportunity to consider both parties' arguments after the benefit of discovery in order to determine whether Honeywell's wellness program violates the ADA and/or GINA."

Supreme Court agrees to hear ACA subsidy case

The Supreme Court agreed to hear *King v. Burwell*, 2014 WL 3582800 (CA 4 2014), a case where the Fourth Circuit Court of Appeals agreed with the IRS that subsidies for the purchase of health insurance should be available to individuals in states with federally-run health insurance Exchanges on the same basis as in states with state-run Exchanges. Currently, there are 17 state-run Exchanges (including Washington D.C.) and 27 federally-run Exchanges (including Ohio) and seven partnership Exchanges jointly run by the state and federal government (which are technically classified as federally-run Exchanges). The Fourth Circuit's decision conflicted with a ruling by a 3-judge panel of the D.C. Circuit Court of Appeals.

Since the employer pay or play penalties are tied to individuals getting subsidies, a Supreme Court decision that subsidies are not available in states with federally-run Exchanges would negate the employer pay or play penalties with respect to employees in those states. More significantly, insurance would become unaffordable for most individuals in those states. If healthier individuals (whose expected medical expenses are less than unsubsidized premiums) decline to buy insurance because they can enroll in future years without any underwriting standards, it could cause a death spiral for the individual health insurance market in those states with federally-run Exchanges.

The Supreme Court will probably hear arguments in *King v. Burwell* in March 2015 with a decision expected in June or July 2015.

DOL green lights state regulation of stop loss coverage

In the face of significant health insurance premium increases, some smaller employers have considered switching from insured health benefits to self-insured health benefits. Of course, it is not financially viable for a small employer to maintain a self-insured health plan without robust stop loss coverage. A small employer choosing to self-insure health benefits might buy a stop loss policy that keeps very little risk for the employer (i.e., has very low individual and aggregate attachment points above which the stop loss carrier pays the claims).

A self-insured health plan can be significantly less expensive than an insured health plan for an employer with relatively healthy employees. However, the federal government wants to keep all small employers in the small group insurance risk pool – especially those with healthy employees. The federal government cannot prohibit a small employer from choosing a self-insured health plan so it is trying a different approach. In Technical Release No. 2014-01 (November 6, 2014), the DOL gave states the green light to regulate stop loss coverage. The DOL made clear that states may enact laws specifying minimum stop loss attachment points. According to the DOL, "a State law that prohibits insurers from issuing stop loss contracts with attachment points below specified levels would not, in the Department's view, be preempted by ERISA." Relatively high minimum stop loss attachment points would make self-insuring health coverage less viable for small employers.