New Developments Under the Affordable Care Act
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I. Introduction and Overview

The Patient Protection and Affordable Care Act (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (HCRA) (collectively, the Affordable Care Act or the ACA), enacted systemic-level reforms to the Medicare and Medicaid programs, the market for health insurance policies purchased directly by individuals from insurance company issuers, and employer-sponsored group health plans. To understand the implications of recent developments under the ACA, it is important to understand how the three-part "system" of the ACA (public programs, the private insurance market, and employer-sponsored plans) was intended to operate. This introduction presents an overview of how the three major mechanisms of the ACA are supposed to coordinate to expand the scope of health insurance coverage.

Congress designed national health care reform under the ACA as a series of changes to be phased in over a period of several years. The first wave of reforms became effective on January 1, 2011. This first wave prohibited lifetime dollar limits and restricted annual dollar limits on essential health benefits offered by group health plans, prohibited preexisting condition coverage exclusions for children under age 19, and generally required that adult children must be offered coverage under a parent’s group health plan through age 26. New plans or existing plans that lost their “grandfathered” status after March 23, 2010 (the effective date of the ACA) were subject to additional substantive benefit requirements. (These requirements are described in detail later in the materials.)

The second wave of reforms involved changes to the Internal Revenue Code to raise revenue to pay for the tax-subsidized expansion of health insurance coverage starting in 2014. The last revenue provision currently is scheduled to become effective in 2018, when a 40% nondeductible excise tax is imposed on so-called “Cadillac” health insurance plans. A “Cadillac” health care plan is defined as a plan that has annual premiums in excess of $10,200 for single coverage or $27,500 for family coverage (indexed for inflation in future years). The 40% excise tax is assessed only on the portion of the annual premium that exceeds these dollar amounts. For fully insured plans, the issuer of the policy is responsible for paying the tax. For self-insured plan, it is the plan’s administrator who must pay the tax. As a practical matter, this tax predominantly impacts multemployer health insurance plans for workers who are represented by a collective bargaining unit. In these collectively-bargained plans, the employer typically pays most (if not all) of the premium pursuant to the terms of a collective bargaining agreement.

The third wave of major reforms required individuals to have minimum essential coverage. See generally Code § 5000A. Individual taxpayers without minimum essential coverage (including
the dependents of the taxpayer) are subject to a minimum tax penalty under Code Section 5000A (unless an exemption applies). This penalty amount is the greater of a fixed penalty amount or a percentage of a formula amount based on the taxpayer’s modified adjusted gross income. The minimum fixed penalty amount is set at $325 in 2015, and will increase to $695 in 2016 and beyond. This requirement (known as the individual mandate) was upheld by the Supreme Court under the Taxing Clause of the United States Constitution in *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012).

To assist uninsured individuals in obtaining minimum essential coverage, the ACA as originally enacted provided for three avenues for individuals to obtain coverage:

(1) *Expanded coverage through employer-sponsored group health plans.* This requirement (known as the employer mandate) imposed penalties on large employers who failed to offer minimum essential coverage to their full-time employees, or who offered coverage to full-time employees that was not affordable or that did not provide an adequate package of substantive health care benefits (known as the 60% minimum value requirement) to the plan’s participants. For purposes of the employer mandate, a “large” employer is defined as an employer who has the equivalent of 50 full-time equivalent employees. An “employer” is defined as including a controlled group of employers under Code Sections 414(b), (c), (m) and (o). See generally Code § 4980H. A “full-time” employee is one who works on average 30 hours of service per week. Hours are counted in the same way as hours of service for purposes of determining eligibility for participation in a qualified retirement plan. The hours worked by part-time or seasonal workers are added together to estimate the number of full-time equivalent employees. See Code § 5000A, 78 Fed. Reg. 218 (Jan. 2, 2013).

(2) *Expanded coverage through individual policies purchased on an Exchange.* The ACA created a system of on-line marketplaces (known as the “American Health Benefit Exchanges” or just the “Exchange” for short) so that insurance companies could market and sell individual health insurance policies that satisfy state and federal standards for the coverage of essential health benefits. Policies sold on an Exchange are available only to United States citizens and legal residents. Individual policies sold on an Exchange must cover pre-existing health conditions. The premiums for policies sold on an Exchange are priced according to a community rating (rather than according to the individual health status of the person(s) covered by the policy). The ACA provided that each State may establish an Exchange for the purchase of individual policies by its residents, or may opt to use the federal Exchange created and operated by the Department of Health and Human Services. For individuals and families with incomes between 100% and 400% of the federal poverty level, the ACA authorized premium assistance tax credits to reduce premium costs. (This premium assistance tax credit mechanism is the subject of the pending Supreme Court case of *King v. Burwell*, discussed later in the materials.)

(3) *Expanded coverage through state-operated Medicaid programs.* The ACA expanded the scope of the jointly-funded, but state-operated, federal Medicaid program by requiring each state to provide Medicaid coverage to all adults under the age of 65 with incomes up to 133% of the federal poverty level. The ACA further required that all of these new Medicaid recipients must have a specified package of benefits. This expansion of Medicaid coverage was a significant change in federal health care policy because prior to the enactment of the ACA an
individual could not qualify for Medicaid coverage merely on the basis of income. Rather, eligibility for Medicaid coverage was limited to four categories of low-income persons: (1) the disabled; (2) the blind; (3) the elderly; and (4) families with dependent children. Due in part to these additional eligibility restrictions, at the time the ACA was enacted on average the states covered only adults making less than 37% and parents making less than 63% of the federal poverty level. See NFIB v. Sebelius, 132 S. Ct. at 2601. The ACA increased federal Medicaid funding to the states by covering 100% of the additional cost of this expanded Medicaid coverage through 2016, with the additional federal funding for expanded Medicaid coverage gradually decreasing to 90% in subsequent years. If a state failed to provide expanded coverage, the ACA authorized the Secretary of the Department of Health and Human Services to withhold all federal Medicaid funds from the state.

The implementation of each of these three assistance mechanisms was delayed, or its impact in terms of expanding health insurance coverage was reduced, by subsequent events. These events began in July of 2013, when the federal government delayed enforcement of the employer mandate, first until January 1, 2015, and later until January 1, 2016 for employers who have between 50 and 99 full-time equivalent employees. The establishment of the Exchange system was made far more difficult when 36 states ultimately opted not to operate an Exchange and chose to rely instead on the federal Exchange operated by the Department of Health and Human Services. Finally, 26 states successfully challenged the mandatory expansion of Medicaid coverage. The Supreme Court held in NFIB v. Sebelius, 132 S. Ct. 2566 (2012), that the mandatory expansion of Medicaid coverage was an unconstitutional expansion of Congress’s authority under the Spending Clause. As a result, eligibility for expanded Medicaid coverage based solely on income was not implemented in all states, but rather on a state-by-state basis.

II. How the ACA Regulates Group Health Plans

A. Substantive Benefit Requirements for Group Health Plans

The ACA created new federal requirements for the substantive package of benefits that must be offered by group health plans sponsored by private and governmental employers. Certain of these benefit requirements do not apply to so-called “grandfathered” plans. A grandfathered plan is an insured or self-insured plan in existence on March 23, 2010, that has not made a subsequent disqualifying change to the terms of the plan. The table below summarizes the major ACA requirements that are applicable to grandfathered and non-grandfathered group health plans.
Major ACA Requirements for Group Health Plans

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Application</th>
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<tbody>
<tr>
<td>Lifetime and annual dollar limits on essential health benefits prohibited;</td>
<td>All Plans</td>
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<td>pre-existing condition coverage exclusions prohibited; waiting periods</td>
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<td>restricted</td>
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<td>Required coverage of minor children and adult children up to age 26</td>
<td>All Plans</td>
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<td>Prohibition on rescission of coverage</td>
<td>All Plans</td>
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<td>Automatic enrollment of workers in group health plans sponsored by very</td>
<td>All Plans</td>
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<td>large employers (200+ employees)</td>
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<td>Mandatory coverage with no participant-cost sharing of immunizations and</td>
<td>Grandfathered plans exempt</td>
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<td>preventive care services</td>
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<td>In-network coverage of emergency care services</td>
<td>Grandfathered plans exempt</td>
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<td>Patient choice of physicians for maternity and pediatric services</td>
<td>Grandfathered plans exempt</td>
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<td>Independent external review of denied claims for plan benefits</td>
<td>Grandfathered plans exempt</td>
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<td>Coverage of all ten essential health benefits</td>
<td>All self-insured plans and</td>
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<td>insured plans in the large</td>
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<td>employer market are exempt</td>
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<tr>
<td>Limits on maximum out-of-pocket payments by participants</td>
<td>Grandfathered plans exempt</td>
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1. Requirements for Maintaining Grandfathered Plan Status

As indicated by the above table, grandfathered plans are exempt from many of the substantive benefit requirements of the ACA. The statutory language of the ACA itself is cryptic concerning the types of changes that will cause a plan to lose its grandfathered status. According to the statute, a plan may enroll family members of existing participants and new employees and their family members in the plan without losing its grandfathered status. For collectively bargained group health plans, grandfathered plan status ends automatically when the collective bargaining agreement under which the plan was established expires. A plan may make amendments to conform to the requirements of state or federal law and may increase the plan’s premiums without
losing its grandfathered status. See ACA § 1251(a)–(d). Other than these brief statutory provisions, the ACA is silent concerning the requirements for maintaining grandfathered plan status.

Department of Labor regulations implementing the ACA provide more guidance for plan sponsors who desire to maintain grandfathered plan status. See generally 75 Fed. Reg. 34,538 (June 17, 2010), as amended by 75 Fed. Reg. 70,114 (Nov. 17, 2010). The Department of Labor regulations for maintaining grandfathered status focus on: (1) the benefits package offered by the plan or the insurance policy that constituted the grandfathered plan as of March 23, 2010; (2) the costs (other than premiums) borne by the participants in the grandfathered plan as of March 23, 2010; and (3) the employer contribution to the plan as of March 23, 2010. With limited exceptions, a change in any one of these three areas results in a loss of grandfathered plan status. An insured plan retains its grandfathered status if the employer changes its insurance carrier so long as the new policy does not make any of the above-described changes that would otherwise trigger a loss of grandfathered plan status. See 75 Fed. Reg. at 70,117. Any elimination of benefits to diagnose or treat a particular condition will result in the loss of grandfathered plan status. For changes to cost-sharing by plan participants, the Department of Labor regulations distinguish between cost-sharing and fixed-amount cost-sharing. For co-insurance, any percentage increase in the portion the participant must pay is a disqualifying change. For example, if the grandfathered plan required a participant to pay 20% of the cost of benefits and later increases the co-insurance percentage to 30%, the change would cause the plan to lose its grandfathered plan status. For fixed-amount cost sharing, such as co-payments for services such as office visits, a numeric formula permits the plan to increase the fixed amount of the co-payment to maintain pace with medical inflation. For employer contributions, the employer generally cannot decrease its contribution rate for any class of similarly situated individuals by more than 5% below the rate in effect on March 23, 2010.

To maintain grandfathered plan status, additional administrative paperwork is necessary. The plan administrator or the insurance company that issues the plan’s policy must provide notice to the participants that the plan is a grandfathered plan. The burden of proof of grandfathered plan status rests with the plan administrator or the policy issuer, who must maintain records and documentation proving that the plan has maintained its grandfathered plan status.

2. Substantive Benefit Requirements for All Group Health Plans

The Affordable Care Act applies to governmental plans, which are not subject to regulation under Title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. (ERISA). Consequently, many of the federal requirements described below were enacted as amendments to the Public Health Services Act, 42 U.S.C. § 300gg et seq. (PHSA), and incorporated by reference into ERISA and the Internal Revenue Code, 26 U.S.C. §1 et seq. (Code). See generally ERISA § 715; Code §§ 4980D, 9815. Citations below are to the appropriate section of the particular statute that created the requirement.

Under the ACA, all group health plans are prohibited from imposing a waiting period for the commencement of benefits under the plan that is longer than 90 days. (Individuals are not penalized for a lack of coverage during the plan’s waiting period under the individual mandate.) In addition, all group health plans are prohibited from imposing preexisting condition coverage exclusions on adults.
All group health plans are prohibited from imposing a preexisting condition coverage exclusion for minor children under age 19. ACA § 10103(e); HCRA § 2301. In addition, all group health plans are required to offer coverage to an adult child of a plan participant until the child turns age 26, regardless of the child’s marital status, full-time student status, or financial support by the parent. ACA § 1001 (adding PHSA § 2714); HCRA § 2301. For administrative convenience, some plans allow a child who turns age 26 to remain on the parent’s plan until the end of the month, or even until the end of the plan year. If an adult child is enrolled in the plan and loses coverage due to the attainment of age 26, the loss of “dependent” coverage under the employer’s plan is treated as a COBRA qualifying event and the adult child is entitled to up to 36 months of COBRA continuation coverage. A plan cannot charge a separate or higher premium for coverage of an adult child than for a minor child of the parent. Conforming amendments to the Code provide that the employer’s contribution to the plan is not treated as taxable income to an adult child who is covered under the plan. See IRS Notice 2010–38.

All group health plans are prohibited from rescinding coverage once an individual is enrolled in the plan, unless the individual has engaged in fraud or intentional misrepresentation in enrolling in the plan. ACA § 1001 (adding PHSA § 2712); HCRA § 2301. This requirement reinforces the nondiscrimination provisions of ERISA Section 702, which prohibit a group health plan from basing an individual’s eligibility to enroll in the plan on a health-related factor. See ERISA § 702(a)(1)(A)–(H). Cancellation of coverage due to the participant’s failure to make a timely premium payment is not considered to be a prohibited rescission of coverage.

3. Additional Requirements for Non-Grandfathered Plans

All non-grandfathered group health plans are required to provide first-dollar coverage of all immunizations and preventive care services. The plan cannot require participants to share in the cost of these benefits by subjecting immunizations and preventive care services to deductibles or co-payments. ACA § 1001 (adding PHSA § 2713). With regard to emergency services, non-grandfathered plans cannot require pre-authorization for these services and must treat all emergency services as in-network. ACA § 1001 (making group health plans subject to the requirements of PHSA § 2719A).

The list of preventive services that must be offered by non-grandfathered plans at no cost to the plan’s participants includes all FDA-approved contraceptive methods and sterilization procedures for women along with related counseling. After several preliminary attempts at drafting regulatory guidance that would accommodate the objections of business owners with strongly held religious beliefs that guide their business operations, religious groups, and religiously-affiliated employers, the federal government issued final regulations on July 2, 2013. See 78 Fed. Reg. 398, 701 (July 2, 2013) (describing in detail the history of the conflict and prior attempts at accommodations). A few months after the issuance of final regulations, the Supreme Court agreed to hear two cases in which employers challenged the mandatory coverage of certain contraceptive methods on religious grounds. In each case, the owners of a closely-held, for-profit corporation challenged the requirement of mandatory contraceptive coverage as an unconstitutional interference with the free exercise of religion under the First Amendment, and as a violation of the federal Religious Freedom Restoration Act, 42 U.S.C. § 2000bb (RFRA). In Burwell v. Hobby
Lobby Stores, Inc., 134 S. Ct. 2751 (2014), the Supreme Court ruled that the contraceptive mandate as applied to the companies was a violation of the RFRA.

Group health plans with managed care features historically have placed restrictions on the participant’s access to treatment by requiring that referrals to other doctors must be made by a designated primary care physician. Under the ACA, a non-grandfathered group health plan that provides for the designation of a primary care physician must permit a child who is covered under the plan to select an available pediatrician as the child’s primary care physician. Female participants in the plan must have direct access to obstetrical or gynecological care without having to obtain a referral or an authorization from a primary care physician. ACA § 1001 (making group health plans subject to the requirements of PHSA § 2719A).

Under ERISA, a participant in a group health plan must appeal a claim for plan benefits that has been denied using the plan’s internal administrative review process. See generally ERISA § 503. Once the internal administrative appeal process has been exhausted, the participant may challenge the plan administrator’s decision by filing a claim in federal or state court under ERISA Section 502(a)(1)(B). In response to concerns about the objectivity of the internal administrative review process, several states enacted independent external review procedures for claims that were denied by insured plans or HMOs. In Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002), the Supreme Court held that these state-operated independent external review processes were not preempted by ERISA Section 514. In the wake of the Supreme Court’s decision in Moran, many more states enacted independent external review programs for denied claims. But these state-based procedural alternatives to ERISA litigation did not exist in every state, and they did not apply to self-insured plans by virtue of ERISA’s deemer clause, ERISA § 514(b)(2)(B). See generally FMC Corp. v. Holliday, 498 U.S. 52 (1990).

The ACA added the option of independent external review of denied claims to participants in all non-grandfathered plans, including non-grandfathered self-insured plans. See ACA § 1001. Grandfathered self-insured plans remain exempt from federal and state independent external review procedures for denied claims. The ACA requires that state-operated independent external review programs must include various consumer protection standards. See PPACA § 1001 (adding PHSA § 2719). Under regulatory compliance guidelines issued by the Department of Labor, the states have until January 1, 2016, to implement these consumer protection standards. See DOL Technical Bulletin 2013–01.

Non-grandfathered self-insured plans can satisfy the independent external review requirement by contracting with at least three accredited private independent review organizations (IROs) and rotating assignments among them. See 76 Fed. Reg. 37,208, 37,211 (June 24, 2011); DOL Technical Bulletin 2010–01, as modified by Technical Release 2011–02. Each state determines the scope of denied claims that are eligible for independent external review under its state-operated process. The scope of denied claims by participants in self-insured plans that are eligible for independent external review by IROs is determined by Department of Labor regulations. See 76 Fed. Reg. at 37,211, 37,216. In general, any claim that involves the exercise of medical judgment is subject to independent external review. See 76 Fed. Reg. at 37,216 (providing examples). The decision of the independent external reviewer is binding on the plan administrator and cannot be appealed through litigation in the courts. Similar consumer protection
standards apply to the independent review processes operated by accredited IROs for participants in self-insured plans. In the self-insured plan context, however, the request for independent external review is submitted to the plan administrator, who then assigns the claim to one of the plan’s IROs for review.

To give all employers greater access to group health insurance, the ACA requires that insurance issuers must issue a policy to an employer who applies for a new group health insurance policy. The insurance company also must renew the employer’s coverage under a group policy if requested by the employer. Although the insurance company cannot cancel the employer’s group policy based on an adverse claims experience, the ACA does not restrict the premium amount that the insurance company may charge for the renewed policy.

All non-grandfathered self-insured plans and non-grandfathered insured plans that are sold in the large employer market must set out-of-pocket annual limits for participants that cannot exceed $6,350 for employee-only coverage and $12,700 for family coverage. Significantly, out-of-pocket limitations do not include the cost of monthly premiums for coverage, which are not regulated by the ACA. For non-grandfathered insured plans that are sold in the small employer market, the maximum out-of-pocket limits are $2,000 and $4,000 for employee-only and family coverage, respectively. These dollar amounts are indexed for inflation in future years. The effect of these much lower maximum out-of-pocket amounts is that the insurance issuer must charge a higher monthly premium for an insured plan sold on the small employer market.

4. Rules for Coverage of Essential Health Benefits

The ACA requires that only certain types of group health plans must provide coverage of the full range of ten essential health benefits. The ACA’s ten essential health benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization coverage
- Maternity and newborn care services
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drug coverage
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care for children under age 18

ACA § 1302(b); 78 Fed. Reg. 12,834 (Feb. 25, 2013). All non-grandfathered insured group health plans sold in the small employer market must provide the complete range of ten essential health benefits without any lifetime or annual dollar limitations. This requirement also applies to any policies sold to individuals through an Exchange. Insured group health plans sold on the large employer market, self-insured plans sponsored by employers of any size, and grandfathered insured plans are not required to offer the full range of ten essential health benefits. Of course, many of these exempt plans do offer most of the essential health benefits voluntarily. Moreover,
insured plans may already be required to cover many of the ten essential health benefits under state

5. Code Section 4980D Penalties

The ACA’s substantive benefit requirements for group health care plans are enforced through a nondeductible excise tax penalty imposed on the employer who sponsors the group health plan. The penalty amount is $100 per day (indexed for inflation), per individual affected, for failure to comply with a requirement. See Code §§ 4980D; 9801–02, 9811–12, 9815 (added by ACA § 1562). For an unintentional failure “due to reasonable cause and not due to wilful neglect,” the maximum excise tax amount that can be assessed in a taxable year for a single employer plan cannot exceed the lesser of: (1) 10% of the employer’s group health plan expenses in the prior year; or (2) $500,000. See Code § 4980D(b)(3). This limitation does not apply if the employer knowingly refuses to comply with a requirement without “reasonable cause.” Thus, as explained by the Supreme Court in Burwell v. Hobby Lobby Stores, Inc., 134 S.Ct. 2751 (2014), the maximum penalty amount of $100 per day, per individual employee (an annual amount of $36,500 per employee) is imposed for an employer who refuses to comply with one of the ACA’s substantive benefit requirements. Group health plan participants or beneficiaries also may bring a private civil action under ERISA Section 502(a)(3) to enforce the federal requirements for group health care plans.

B. The Employer Mandate


The ACA requires that, unless an exemption applies, all individuals are required to maintain minimum essential coverage through a federal or state program, an employer-sponsored group health plan, or an individual health insurance policy for themselves and their dependents. Individuals who fail to maintain minimum essential coverage for themselves and their dependents must pay a tax penalty (the individual mandate). See generally Code § 5000A.

As originally enacted, the individual mandate was paired with the employer mandate. The individual mandate went into effect as scheduled on January 1, 2014. On July 2, 2013, the Treasury Department announced that it would not enforce the employer mandate until January 1, 2015. Later, the Treasury Department announced that only employers with 100 or more full-time equivalent employees must provide minimum essential coverage in 2015, and that coverage during 2015 only had to be provided to 70% of full-time employees. Employers with 50 or more full-time equivalent employees must provide minimum essential coverage to 95% of their full-time employees beginning January 1, 2016.

The employer mandate applies only to “large” employers. See Code § 4980H. For purposes of triggering the employer mandate, the ACA defines a large employer as one who employs on average at least 50 or more full-time equivalent employees. See id. To determine large employer status for purposes of the employer mandate, the employer looks backward to the prior calendar year when counting employees and hours of service. A full-time employee is defined as one who is regularly scheduled to work 30 or more hours of service per week. To calculate the number of
“equivalent” full-time employers, the employer first must count the number of actual full-time employees. Next, the employer must aggregate the number of hours worked by its part-time employees for each month and divide this monthly total by 120 to determine the number of “equivalent” full-time employees for that month. This month by month count of “actual plus equivalent” full-time employees is then totaled and usually divided by 12 to determine whether or not the employer employed an average of 50 or more full-time equivalent employees during the prior calendar year. If an employer is in business for only part of a calendar year, then the calculation is prorated so that only the operational months are used to determine large employer status. See Code § 4980H(c)(2)(E). A statutory exemption applies for employers who have seasonal workers. See Code § 4980H(c)(2)(B). Hours of service are measured in the same manner as the minimum participation rules for qualified retirement plans. Employees of employers who are part of a controlled group under Code Sections 414(b), (c), (m), or (o) are aggregated to determine large employer status. In addition, leased employees under Code Section 414(n) are counted as employees of the employer.

Employers who employ on average fewer than 50 full-time equivalent employees are classified as “small” employers. Small employers are not required to offer minimum essential coverage through a group health plan to their employees.

2 Code Section 4980H Penalties

The employer mandate is contained in Code Section 49804H. Section 4980H has two components, each with a different employer penalty for noncompliance. The first component, known as the play or pay penalty, is set forth in Section 4980H(a). The second component, known as the free rider penalty, is found in Section 4980H(b). Each component has its own unique design features, but certain common concepts are fundamental to the operation of each penalty.

The play or pay component of Section 4980H(a) provides as follows:

(a) Large Employers Not Offering Coverage.
If—
(1) any 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 (as defined in section 5000A(f)(2)) for any month, and
(2) at least one-full-time employee of the applicable large employer * * * [qualifies and has] enrolled for such month in a qualified health plan [offered through an Exchange] with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount [defined under Section 4980H(c)(1) as 1/12 of $2,000, or $2,000 on an annual basis] and the number of individuals employed by the employer as full-time employees during such month.
Although the statutory language of the play or pay penalty appears to be straight-forward, there are several important concepts imbedded in this relatively brief provision. First, the employer is required to offer coverage only to its full-time employees (defined in Code Section 4980H(c)(4)(A) as those individuals who are regularly scheduled to work at least 30 hours of service per week), even though the calculation of large employer status triggering the employer mandate requires aggregating the hours of service worked by part-time employees. This distinction also applies for the purpose of assessing the penalty for noncompliance. The play or pay penalty is triggered only if a full-time employee applies for individual coverage through an Exchange and qualifies on the basis of income for a premium assistance tax credit. The penalty of $2,000 on an annual basis is assessed based on the total number of full-time employees employed by the employer, even if only one full-time employee applies for and receives coverage through an Exchange policy and qualifies for a premium assistance tax credit.

To ensure compliance with the play or pay rule of Section 4980H(a), the employer may take advantage of the 95% compliance rule. Under the 95% compliance rule, no penalty is assessed under Section 4980H(a) if the employer offers minimum essential coverage to all but 5% of its full-time employees, or, if greater, five full-time employees. The 95% compliance rule “is designed to accommodate relatively small applicable large employers…[and] applies to the failure to offer coverage to the specified number or percentage of employees (and their dependents), regardless of whether the failure to offer was inadvertent.” 78 Fed. Reg. 218, 232–33 (Jan. 2, 2013). In other words, under the 95% compliance rule the employer can designate which full-time employees are to be excluded from coverage under the employer’s plan.

In assessing the play or pay penalty, the first 30 full-time employees of the employer are not counted. See Code § 4980H(c)(1) (defining penalty), (c)(2)(D) (penalty calculation reduced by 30 full-time employees). In other words, so long as the number of full-time employees is limited to 30 or less, the employer will not be subject to the play or pay penalty for failing to offer minimum essential coverage to its employees. Consequently, the design of the play or pay penalty provides an incentive for employers to restrict the number of their actual full-time employees and to use more part-time workers to operate their businesses.

A second important concept imbedded in the statutory language of Section 4980H(a) is the distinction between coverage offered to the individual employee (known as employee-only or self-only coverage), coverage offered to the employee’s dependents, and coverage offered to an employee’s spouse. (Family coverage applies to the employee, the employee’s spouse, and any dependents.) Section 4980H(a) requires that the employer must offer coverage only to employees and their dependents. The employer is not required to offer spousal coverage (although many employers are likely to continue to do so voluntarily by offering family coverage). The distinction between self-only coverage and dependent coverage arises again later in the determination of affordable coverage, a concept that underlies the free rider penalty component of the employer mandate under Code Section 4980H(b).

The third important concept imbedded in Section 4980H(a) is minimum essential coverage, a technical term that only superficially resembles the concept of essential health benefits. The concept of minimum essential coverage mirrors the requirement of the individual mandate under
Code Section 5000A, which is incorporated by reference in both Sections 4980H(a) and 4980H(b). Code Section 5000A(a) provides as follows:

(a) Requirement to Maintain Minimum Essential Coverage
An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

For purposes of both the employer and individual mandates, minimum essential coverage is defined in Code Section 5000A(f)(2) as including coverage under an employer-sponsored plan, including a grandfathered plan, that offers more than just “excepted benefits” under Sections 2791(c)(1) through (c)(4) of the Public Health Services Act. Excepted benefits consist of:

- benefits that are not considered health coverage, such as accidental death and disability income insurance or worker’s compensation;
- benefits that are offered separately or are not an integral part of a health plan, such as dental or vision insurance for adults or long-term care insurance;
- benefits that are offered separately and not coordinated with benefits under another group health plan, such as insurance coverage for a specific disease (e.g., cancer) or a fixed indemnity amount for hospitalization; or
- benefits offered as a separate insurance policy and supplemental to Medicare, Armed Forces health care coverage, or (in very limited circumstances) group health plan coverage.

To illustrate, a plan that offers only dental or vision care for adults as its benefit would not constitute minimum essential coverage because dental and vision care for adults are excepted benefits. But if a large employer offered a group health plan that provided only preventive care services and immunizations, such a plan would qualify as minimum essential coverage under the Code Sections 4980H and 5000A. See 78 Fed. Reg. 218, 220 (Jan. 2, 2013).

Why would a large employer choose to offer a group health plan that provides such a minimal range of benefits? The first incentive is obviously cost-reduction. Although any essential health benefit that is covered by a minimum essential coverage plan cannot be subject to lifetime or annual limits, if the plan’s coverage is restricted to only one or a few such benefits, the premium price is greatly reduced. A second (and closely related) employer incentive is to avoid the play or pay penalty component of Section 4980H(a), which only requires the employer to provide minimum essential coverage (not the full range of ten essential health benefits). Third, the demographic composition of the employer’s workforce may provide an incentive. If the employer’s workforce consists of younger or part-time employees (all of whom must satisfy the individual mandate, or else pay a tax penalty under Code Section 5000A), an employer who offers a minimum essential coverage plan at a very low monthly premium may be highly attractive to
employees, who can obtain minimum essential coverage as required by the individual mandate at a minimal price.

Obviously, the play or pay penalty component of the employer mandate alone is not an effective mechanism for achieving the policy goal of universal health insurance coverage. Code Section 4980H(a) does not address whether the minimum essential coverage offered by the employer to its full-time employees is affordable, or whether the plan’s package of substantive benefits is adequate. Affordability and adequate coverage are addressed by Code Section 4980H(b), which provides as follows:

(b) Large Employers Offering Coverage With Employees Who Qualify For Premium Tax Credits Or Cost-Sharing Reductions

(I) In general

If—

(A) 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 (as defined in section 5000A (f)(2)) for any month, and

(B) 1 or more full-time employees of the applicable large employer * * * [qualify and are] enrolled for such month in a qualified health plan [offered through an Exchange] with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and an amount equal to 1/12 of $3,000 [or $3,000 on an annual basis].

Code Section 4980H(b) is known as the free rider penalty because it addresses the policy concern that employers could offer health insurance coverage to all of their full-time employees (thus satisfying Section 4980H(a)), but at a premium price that may be unaffordable for full-time, but lower income, employees. If the premium charged for coverage under the employer’s plan is unaffordable, lower income employees would be better off by purchasing an individual health insurance policy through the Exchange system using premium assistance tax credits. Section 4980H(b) is designed to deter employers from “free-riding” on the Exchange system of premium assistance tax credits available to individuals who have a household income that is between 100% and 400% of the federal poverty level.

The key to Code Section 4980H(b) is the triggering mechanism for assessment of the penalty, which requires that a full-time employee of the large employer must receive coverage through an Exchange policy and must qualify for a premium assistance tax credit. An employee who is eligible for coverage offered through a group health plan that provides minimum essential coverage, but who instead purchases an Exchange policy, is not eligible for a premium assistance tax credit if: (1) the employer’s plan has an actuarial minimum value of at least 60% (as measured by federal regulations); and (2) the employee’s share of the premium for self-only coverage under the employer’s plan does not exceed 9.5% of the employee’s household income. See Code § 36B(c)(2)(C)(i)–(ii) (defining employer-sponsored minimum coverage that is affordable and
provides minimum value); see generally 78 Fed. Reg. 12,834 (Feb. 25, 2013) (proposed regulations for actuarial methods used to determine minimum value); 78 Fed. Reg. 218 (Jan. 2, 2013) (proposed regulations for employer shared responsibility under Code Section 4980H); IRS Notice 2014–69 (plans that fail to provide coverage for in-patient hospitalization services or physician services do not satisfy the minimum value requirement). If an employee or a member of the employee’s family enrolls in an employer-sponsored group health plan, then the enrollee cannot qualify for a premium assistance tax credit to purchase additional coverage under an Exchange policy. See Code § 36B(c)(2)(C)(iii).

Final regulations issued by the Treasury Department took the controversial position that “affordability” is based on the cost of employee-only coverage under the employer’s plan. See Treas. Reg. § 1.36B–2(c)(3)(v)(A)(2). This interpretation provides an incentive for employers to reduce the premium for employee-only coverage, but to increase the premiums for required dependent coverage (which must be offered by the employer to children of employees up to age 26) and optional spousal coverage. See 78 Fed. Reg. 218, 231–32, 241 (Jan. 2, 2013). The ACA does not prohibit employers from charging higher premiums for dependent, spousal, or family coverage, and does not regulate the affordability of such premiums.

Assuming a large employer successfully avoids the play or pay penalty of Section 4980H(a), what is the financial risk associated with the free rider penalty under Section 4980H(b) if the employer’s plan is unaffordable for some employees, or if the plan fails to provide minimum value? Note that the potential free rider penalty is limited under Section 4980H(b) to the maximum possible play or pay penalty (which includes the reduction for the first 30 full-time employees of the employer). See Code § 4980H(b)(2)(D)(i). If the employer does not have more than 30 full-time employees who have a household income that is between 100% and 400% of the federal poverty level (thereby qualifying for a premium assistance tax credit to offset the cost of an Exchange policy), the employer will not be penalized at all if the employer’s plan is unaffordable or fails to provide minimum value. In addition, a free rider penalty is assessed only for the 31st and subsequent employees who purchase an individual policy on an Exchange and receive premium assistance tax credits.

A second, albeit indirect, limitation on the free rider penalty is the price charged for Exchange policies in the employer’s market. Recall that the free rider penalty is assessed only if a full-time employee actually purchases an Exchange policy and qualifies for a premium assistance tax credit based on household income. Some Exchange markets may offer policies at a premium price that, notwithstanding the premium assistance tax credit, exceeds the individual mandate penalty amount under Code Section 5000A. In this situation, the employee may prefer to pay the penalty rather than purchase a health insurance policy through the Exchange.

It is important to note how the 60% minimum value requirement constrains the ability of the employer to make the plan more affordable by reducing the substantive health care benefits covered under the plan. The design of the benefits package under the plan and the relative amounts contributed by the employer and the plan’s participants will determine whether the plan satisfies the actuarial standard of “minimum value.” See generally IRS Notice 2012-31; 78 Fed. Reg. 12,834 (Feb. 25, 2013) (final rule on minimum value); IRS Notice 2014–69. For example, a plan that covers only preventive care services and immunizations, or excludes coverage of in-patient
hospitalization services or physician services, can charge a reduced premium amount, but such a plan will fail the 60% minimum value requirement.

Treasury Regulations attempt to reduce the compliance burden on the employer regarding the estimation of an employee’s household income for purposes of the employer mandate penalties under Code Section 4980H. Under the individual mandate of Code Section 5000A, it is household income that determines eligibility for a premium assistance tax credit, which in turn can trigger the employer mandate penalties under Code Section 4980H. To assist employers, the Treasury Department has issued regulations that create three safe harbor mechanisms for employers to use in determining whether the plan’s premiums are affordable for low-income, full-time employees. The most simple safe harbor to apply allows the employer to substitute the employee’s wages and other income reported on Form W-2 for the employee’s household income when analyzing the affordability of the plan for its full-time workers. See generally 78 Fed. Reg. 218 (Jan. 2, 2013) (adopting IRS Notice 2011–73).

II. Supreme Court Developments: King v. Burwell

A. History of the Litigation

On March 4, 2015, the Supreme Court heard oral arguments in King v. Burwell. King is a challenge by taxpayers to a Treasury regulation that authorizes the payment of premium assistance tax credits to qualifying individuals who obtain coverage on an Exchange, regardless of whether that Exchange is operated by the individual’s state of residence (State Exchange), or by the Department of Health and Human Services (Federal Exchange).

King presents a question of statutory interpretation for the Supreme Court. Code Section 36B(b)(2)(A) defines a premium assistance tax credit as available for qualifying individuals who enroll in coverage through an “Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.” ACA Section 1311 is the provision that directs the states to establish State Exchanges for their residents. A subsequent provision of the statute, ACA Section 1321, authorizes the federal government to establish a Federal Exchange for any state that fails to establish a State Exchange. The issue in King arose because only 14 states established State Exchanges under Section 1311, with the other 36 states opting to use the Federal Exchange established under Section 1321. On May 23, 2012, the Internal Revenue Service issued a final regulation that authorized the payment of premium assistance tax credits to qualifying individuals who purchased coverage on either a State Exchange or the Federal Exchange. See 77 Fed. Reg. 30,377 (May 23, 2012).

The issuance of this Treasury regulation sparked numerous legal challenges by both private and state government taxpayers. Ultimately, two cases – King v. Burwell in the Fourth Circuit, and Halbig v. Burwell in the D.C. Circuit – emerged as the leading candidates for review by the Supreme Court. On July 22, 2014, the Fourth Circuit Court of Appeals in King and the D.C. Court of Appeals in Halbig came to opposite conclusions concerning the validity of the regulation, thereby creating a circuit split. Halbig ruled for the taxpayers, and King ruled for the federal government. According to the panel opinion in Halbig (which was released just hours
before the panel opinion in King, “[t]he problem confronting the IRS Rule is that subsidies also turn on a third attribute of Exchanges: who established them.” Halbig, 758 F.3d 390, 400 (D.C. Cir. 2014). After the Fourth Circuit issued its opinion in King, the D.C. Circuit decided to rehear Halbig en banc and vacated the panel opinion. This maneuver eliminated the circuit split and left intact only King, which had upheld the Treasury regulation. On November 7, 2014, the Supreme Court granted certiorari in the King case. As a result, the D.C. Circuit stayed further proceedings in Halbig pending the Supreme Court's decision in King.

B. Potential Implications

The question presented by the taxpayers in King, which the Supreme Court agreed to hear, is as follows:

Section 36B of the Internal Revenue Code authorizes federal tax credit subsidies for health insurance coverage that is purchased through an “Exchange established by the State under section 1311” of the ACA.

The question presented is whether the Internal Revenue Service may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through Exchanges established by the federal government under section 1321 of the ACA.

The implications of the Court's ruling in King are significant for the system of health care reforms enacted by the ACA. If the King taxpayers prevail, employees who reside in Federal Exchange states cannot receive premium assistance tax credits. Thus, if all of an employer's employees reside in a Federal Exchange state, it is impossible to trigger the Section 4980H(a) free rider penalty. In other words, in this situation the employer mandate is eliminated. If the employer does offer health insurance coverage, but that coverage is either unaffordable or does not provide minimum value, the employer will pay the Section 4980H(b) pay or play penalty only for employees who reside in one of the 16 State Exchange states, thereby reducing its impact.

King also has significant implications for the pricing of policies for the 36 states that opted to use the Federal Exchange and the enforcement of the individual mandate. If the King taxpayers prevail, employees who reside in Federal Exchange states cannot receive premium assistance tax credits to offset the cost of purchasing coverage on the Federal Exchange. If the cost of unsubsidized coverage exceeds 8% of an individual’s household income, then the individual is exempt from the individual mandate penalty under Code Section 5000A(e)(1)(A). The likely long-term result would be that millions of healthy individuals will not purchase health insurance policies on the Federal Exchange. The result would be a so-called "death spiral" as the premiums for Federal Exchange policies increased dramatically due to adverse selection distortions in the pool of insureds. This adverse selection problem is magnified due to the ACA's requirements of guaranteed issue, no pre-existing condition coverage exclusions, and community-rating pricing for policies sold on an Exchange. It is this same combination of factors that led to health insurance premium death spirals in the 1990s when the states of New York and Kentucky enacted similar health care reform measures for their insurance markets.