New Developments Under the Affordable Care Act

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Prelude: How the ACA Works

• What are the substantive benefit requirements for employer health insurance plans and the penalties for noncompliance?

• When is an employer subject to the employer mandate and what is the potential penalty for noncompliance?
ACA Requirements (All Plans)

- No pre-existing condition coverage exclusions or annual or lifetime dollar limits on any Essential Health Benefit (EHB) covered under the plan
- Waiting periods limited to 90 days
- Mandatory offer of coverage of dependents and adult children to age 26 (*but not spouses*)
- Prohibitions on rescission of coverage

Grandfathered Plans

- Were in existence on March 23, 2010
- Can enroll new employees and add family members of existing participants
- Can switch insurance company policies (so long as the coverage is identical)
- Cannot change the package of benefits offered, the out-of-pocket costs for participants (excluding premiums) and the employer’s contribution to the plan
Additional Requirements (non-grandfathered plans only)

- First dollar coverage of immunizations and preventive care services
- Patient choice for maternity and pediatric services
- Independent external review of denied claims
- Maximum limits on total out-of-pocket payments for participants (but no limits on premiums)

Code § 4980D Penalties for Failing a Substantive Benefit Requirement

- Penalty is $100 per day, per individual affected (or a potential annual penalty of $36,500, per participant).
- There is a cap on the annual penalty for unintentional noncompliance (lesser of $500,000 or 10% of the aggregate amount paid by the employer or the predecessor employer for the group health plan).
- But there is no cap on total penalty for intentional noncompliance (results in a penalty of $36,500 per individual affected, per year).
“Buyer Beware” Hypothetical

- Relying on its insurance agent’s advice, the employer increased the out-of-pocket costs for its participants when it changed to a new insurance policy, but continued to operate as a grandfathered plan for 4 years (resulting in numerous substantive violations of the ACA).

The Ten EHBs

- Ambulatory patient and emergency services
- Hospital services and prescription drugs
- Maternity and newborn care and pediatric services, including pediatric vision and dental benefits
- Mental health and substance abuse disorder services, including behavioral health treatment
- Rehabilitative, laboratory and preventive and wellness services
- Chronic disease management
**EHB v. MEC**

- Minimum Essential Coverage (MEC) is the standard for required coverage under the individual mandate and the first test under the employer mandate (the “play or pay” penalty).
- For employer-sponsored group health plans, MEC is any plan that offers more than just “excepted benefits.”
- Offering any essential health benefit qualifies as minimum essential coverage (e.g., a plan that covers only immunizations, preventive care services, and prescription drugs).

**Why EHB v. MEC Matters**

- Coverage of the ACA’s list of ten EHBs is far more costly than MEC.
- Any EHB offered by the plan cannot have any annual or lifetime dollar limits (nonmonetary limits are ok).
- Only individual insurance policies and small employer group insurance policies must cover the ACA’s required list of ten EHBs.
EHBs and Plan Structure

• Self-insured plans of any size and large employer insured plans can choose their benefits package and do not have to offer all ten EHBs.
• The plan still must pass the second test under the employer mandate to avoid a “free rider” penalty.

The Employer Mandate: FTE v. FEE

• A FTE is defined as an employee who is employed on average 30 hours of service per week.
• The employer mandate is based on the number of full-time equivalent employees (FEEs), not “true” full-time employees (FTEs).
  – Part-time employees hours are totaled, averaged by month based on 30 hours as the full-time equivalent, and then monthly averages are averaged, generally over 12 months.
• Look-back rules apply to determine compliance for the current year based on the prior year.
Why FTE v. FEE Matters

• The employer must offer minimum essential coverage only to FTEs (30 or more hours of service per week on average) and their dependents (but not spouses).
• The penalties for noncompliance with the employer mandate are assessed only for FTEs who are not provided ACA-compliant coverage.
• Note: the first 30 FTEs who are not offered ACA-compliant coverage by the employer are penalty-free (“freebies) in 2016 and thereafter.

Timeline

2014
- Individuals must have MEC or pay a tax penalty (min. $95)
- All benefit requirements apply to employer-sponsored plans

2015
- Employers with 100 or more FTEs must provide MEC to 70% of FTEs (first 80 FTEs are penalty free)
- Individual mandate penalty increases (min. $395)

2016
- Employers with 50 or more FEEs must provide MEC to 95%* of FTEs (first 30 FTEs are penalty free)
- Individual mandate penalty increases (min. $695)

* The “95% rule” allows an employer to exclude up to 5% or, if greater, 5 of its FTEs from MEC and still be deemed to be in compliance.
Employer Mandate Penalties

Code § 4980H

(Employers who have 50 or more FEEs beginning in 2016)

• Code § 4980H(a) “play or pay” penalty

• Plan must offer minimum essential coverage to 95% of FTEs.

• Penalty is triggered if one FTE purchases individual coverage on an Exchange AND receives a federal premium assistance tax credit.

• Penalty is $2,000 per FTE for ALL FTEs (minus 30 freebies).

Employer Mandate

Code § 4980H

(Employers who have 50 or more FEEs beginning in 2016)

• Code § 4980H(b) “free rider” penalty

• The coverage offered by the employer must be ACA-compliant, meaning it is:
  – affordable (e.g., costs no more than 9.5% of an employee’s household income), and
  – provides 60% minimum actuarial value according to a “base” package of benefits determined by HHS.

• Penalty is $3,000 per FTE who purchases individual coverage on an Exchange AND receives a federal premium assistance tax credit (minus 30 freebies).
Employer Mandate Analysis

• Is the employer subject to Code § 4980H?

• If yes, then what are the employer's options?

• If the employer chooses to offer health insurance coverage, is the premium for employee-only coverage affordable, and does the plan provide minimum value?

Range of Employer Options

• **Option #1.** Offer no health insurance coverage and pay a penalty of $2,000 per FTE.

• **Note:** Under Option #1, the individual employees must either pay the tax penalty under Code § 5000A, or else purchase an individual insurance policy. Recall that the ACA requires individual insurance policies to cover the full list of EHBs, with no annual or lifetime dollar limits on benefits or coverage exclusions.
Range of Employer Options

- **Option #2.** Offer the most inexpensive minimum essential coverage that satisfies Code § 5000A (e.g., a preventive care-only or prescription drug-only plan). Such coverage must be available to employees and their dependents.

- **Note:** Due to state insurance laws, this must be a self-insured plan.

- **Option #3.** Offer health insurance that covers up to all ten EHBs. Such coverage must be available to employees and their dependents.

Example One

Employer has 100 employees who work an average of 29 hours per week, and 30 employees who work an average of 30 or more hours per week. Employer does not offer minimum essential coverage for its employees.

**Step #1:** The Employer has over 50 full-time equivalent employees (FEEs).

**Step #2:** The Employer pays no penalty under Code § 4980H(a) because there are only 30 FTEs, and no penalty is assessed for the first 30 FTEs.
Example Two

Employer has 500 part-time employees who work an average of 20 hours per week, and 100 employees who work an average of 30 or more hours per week. Employer does not offer minimum essential coverage for its employees.

Step #1: The Employer has over 50 FEEs.

Step #2: The Employer must pay an annual penalty under Code § 4980H(a) of $2,000 times 70 FTEs. The total annual penalty amount is $140,000.

Example Three

Employer has 500 part-time employees who work an average of 20 hours per week, and 100 employees who work an average of 30 or more hours per week. Employer offers minimum essential coverage for its employees and their dependents. The premium cost for employee-only coverage is $2,600 per year. Employer contributes $1,400 for each employee who participates in the plan.
Example Three

Step #1: The Employer has over 50 FFEs.

Step #2: The Employer does not incur a penalty under § Code 4980H(a) because it offers minimum essential coverage to employees and their dependents.

Step #3: Estimate the Employer's potential penalty under Code § 4980H(b) based on workforce demographics.

Example Three

• Workforce Demographics Analysis:
  – How many full-time employees have a household income of less than 400% of the federal poverty level and are eligible for a premium assistance tax credit for the purchase of an individual Exchange policy?
  – Is this number over 30?
  – If so, consider further analysis of under the affordability and minimum value tests.
Fair Labor Standards Act § 18C
(Effective Jan. 1, 2014)

(a) PROHIBITION. No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has

(1) received a [premium assistance tax] credit under section 36B of the Internal Revenue Code of 1986…

Fair Labor Standards Act § 18C
(Effective Jan. 1, 2014)

- FLSA § 18C is enforced under OSHA whistle-blower provisions for administrative adjudication (with the option to pursue an unresolved claim in federal court).

The Supreme Court and the Future of the Affordable Care Act

• What are the potential implications of the most recent Supreme Court challenge to the ACA in *King v. Burwell*?

Background: Key Statutory Provisions

• ACA § 1311 – State-established Exchanges
• ACA § 1321 – authorizes a federal government Exchange system for opt-out States
• Only 14 states established their own Exchanges under § 1311.
• 36 states opted to use a federal Exchange under § 1321
IRS Regulatory Interpretation

- Code § 36B (ACA § 1401) authorizes premium assistance tax credits for qualifying individuals who enroll in coverage through an “Exchange established by the State under section 1311.”

- The Service by regulation authorized tax credits to be paid for all Exchanges (77 Fed. Reg. 30,377 (May 23, 2012)).

Legal Challenges

- Two state government challenges (OK, IN)
- Two private employer challenges (Halbig, King)
- July 2014
  - D.C. Circuit rules 2-1 for taxpayers in Halbig
  - Fourth Circuit rules for the government in King
- Halbig panel decision was vacated, with en banc argument first set for December, but later stayed by King)
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.

If the *King* taxpayers prevail…

Employees who reside in federal-Exchange states cannot receive premium assistance tax credits.

If ALL employees reside in federal-Exchange states, it is impossible to trigger an employer mandate excise tax penalty under the ACA.
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 Exchange.

If the cost of unsubsidized coverage exceeds 8% of an individual’s household income, then the individual is exemption from the individual mandate penalty under Code § 5000A.

As more younger and healthier individuals claim exemptions, the premiums for Exchange policies will rise dramatically due to adverse selection distortions in the pool of insureds.