HEALTH & WELFARE PLAN LUNCH GROUP

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2014 Health and Welfare Plan Sponsor Year End Checklist

2014 has been another busy year of regulations and guidance affecting health and welfare benefit plans. We have the Affordable Care Act (ACA) to thank for much of the seemingly endless flow of regulations and guidance in 2014; however, the ACA cannot take full credit. Code Section 125, HIPAA privacy, the Mental Health Parity and Addiction Equity Act, and the ADA—just to mention a few—are each worthy of an honorable mention in the "which laws generated the most late nights" award category for 2014.

Many of the rules and regulations went into effect in 2014 while others were issued in 2014 but will not be effective until 2015 or later. Needless to say, keeping track of the "what" and "when" is a challenge for even the most seasoned benefit professional. To help you ensure that nothing slips through the cracks, we provide below the highlights for 2014.

Affordable Care Act

As in prior years, the ACA occupied the majority of time and compliance effort for health plan sponsors, administrators and benefit advisors. The Departments of Labor, Treasury and Health and Human Services (collectively, the "Agencies") issued regulations and guidance—either independently or jointly--on a wide array of ACA topics. The Supreme Court even joined in with its controversial ruling on a religious based corporation's obligation to cover contraceptives.

The 2014 ACA related highlights include:

- *Employer shared responsibility requirements (aka 4980H or "pay or play" rules):* In February 2014, Treasury issued final regulations with respect to 4980H, which generally go into effect in January 2015. The much anticipated regulations were lengthy and complex and provide material clarification as well as critical transition relief. The IRS also issued Notice 2014-49, which clarified the application of the 4980H rules to employees who transfer between members of a controlled group that use different methods for identifying employees. Highlights of the 2014 guidance related to the 4980H rules include:
    - A 1-year delay (to 2016) for excise taxes for applicable large employers (ALEs) that had less than 100 full-time equivalents in 2014 and *who also satisfied certain additional requirements*—i.e. the delay is not applicable solely because the employer had between 50 and 99 full-time equivalents. Caution: Although ALEs subject to the delay avoid excise taxes in 2015, they must still satisfy the reporting requirements associated with the 4980H rules for 2015 (see discussion below regarding Section 6056 reporting requirements);
    - Clarification that the look back measurement period method for identifying full-time employees applies to *all employees* of the ALE member who are within the same distinguishable class, as defined by the regulations (e.g. salaried or hourly)—i.e. an ALE member cannot simply apply the look back measurement period method to "variable employees".

- Transition relief for certain ALEs that maintain plans that have a non-calendar plan year ("fiscal plan year"). According to the regulations, ALE members can avoid excise taxes with respect to a full-time employee to whom coverage was not offered in the months preceding the start of the fiscal plan year in 2015 (or 2016 if subject to the 1 year delay for certain smaller ALEs) *if certain conditions are satisfied*. Caution: The transition relief isn't automatically available to employers who sponsor plans with a fiscal plan year. It is available only to the extent certain requirements are satisfied (e.g., related to the number of employees or full time employees offered coverage or actually covered), and even then, the relief may only be available for certain employees.
- Transition relief for 2015 that decreases the "substantially all" test threshold from 95% to 70%. In order to avoid the 4980H(a) (or "sledgehammer") tax for a month, ALE members must satisfy the substantially all test. ALE members satisfy the substantially all test in a month if they offer coverage through an eligible employer sponsored plan (as defined in Code Section 5000A) to the applicable percentage of their full-time employees (and their dependent children) for that month.
- Transition relief for 2015 that increases the full-time employee reduction available for employers (the "throw away" rule) subject to the 4980H(a) tax from 30 to 80. If an ALE does not satisfy the substantially all test for a month, the total number of full-time employees on which the excise tax is based is reduced by the ALE member's allocable share of the controlled group's full-time employees, not to exceed applicable full-time employee reduction number. Caution: this increase in the full-time employee reduction from 30 to 80 does not apply to ALEs with less than 100 full-time equivalents (i.e. employers who are not subject to the 1 year delay).
- Clarifications regarding application of the 4980H rules in certain situations in which an ALE's employees receive coverage from an unrelated third party, such as:
  - Multi-employer plans
  - Staffing agencies
- Clarifications regarding the application of the 4980H rules to certain types of employees, such as:
  - Students/interns
  - Bona fide volunteers
  - Employees performing services outside the United States (e.g. Puerto Rico)
- Clarification regarding the calculations of hours of service for certain types of employees, such as:
  - Adjunct faculty
  - On-call employees
- Clarification that an ALE member is not considered to have made an offer of coverage to a full-time employee unless the employee had the opportunity to elect coverage for his/her dependent children (if any) AND that coverage, if elected, would extend through the *end of the month* in which the child turns age 26 (or the date coverage ends for the employee, if earlier).

- Transition relief for plans that did not offer coverage for dependent children on February 9, 2014.

- *Section 6056 Reporting:* The ACA added new Code Section 6056, which requires ALE members to file a form with the IRS that identifies each of the employer's employees who were full-time (as defined in Code Section 4980H) at least one month during the calendar year and what, if any, coverage was offered to those full-time employees. Employers must also furnish that form to the full-time employees. The purpose of the reporting requirement is to assist the IRS with administration of both the 4980H rules and the Code Section 36B premium tax credit rules. In 2014, the IRS issued final regulations with respect to the Section 6056 reporting requirements along with draft forms (1094 and 1095-C) and instructions. The forms have yet to be finalized but they shed significant light on what will be reported and how, such as:

  - Each ALE member is responsible for satisfying the reporting requirements with respect to its full-time employees (although a third party may file on their behalf), even if another member of the controlled group of employers sponsors the health plan in which the applicable large employer member's full-time employees participate.
  - Most of the relevant information with respect to the employer's full-time employees, including the scope of coverage offered to full-time employees (if any), will be provided through various codes. The codes are described in the instructions to the 1094 and 1095-C forms.
  - Employers must generally provide information for all 12 months of the year if an employee is full-time at least one month during the year—even if the employee is not employed by the employer for all 12 months. For example, if an employee is hired in August of 2015 (and is subsequently full-time at least one month such that there is a Code Section 6056 reporting obligation), the applicable large employer member will indicate on the 1095-C—using the applicable codes--that the employee was not employed by the employer January through July.

- *Section 6055 Reporting*: The ACA also added new Code Section 6055, which requires providers of minimum essential coverage to file a form with the IRS that identifies for the IRS each individual who enrolled in minimum essential coverage at least 1 day during the year. Whereas the 6056 requirement applies only to ALEs, and then only with respect to full time employees, this requirement would apply to any employer who sponsors a self-insured plan and any individuals (including retirees and dependents) covered under a plan. Coverage providers must also furnish this form to the covered individuals. The purpose of the Code section 6055 reporting requirements is to help the IRS administer the individual mandate. Employers who sponsor self-insured plans that provide minimum essential coverage (an "eligible employer sponsored plan" as defined in Code Section 5000A) are obligated to satisfy the Code Section 6055 requirements with respect to *ALL* individuals enrolled in the self-insured plan. If the plan is fully insured, the insurance carrier who issues the policy will satisfy the Code Section 6055 obligation with respect to individuals covered under the insurance policy. As they did with the

Section 6056 requirements, the IRS issued final Code Section 6055 regulations in 2014 along with draft forms (1094 and 1095-B) and instructions. Highlights of the Section 6055 reporting requirements, as they relate to employers with self-insured plans, include:

- Each employer whose employees participate in a self-insured plan—even if the plan sponsored by another employer- is independently responsible for filing the forms; however, a third party may file on behalf of the employer. NOTE: Employers who contribute to multi-employer plans are *not* obligated to satisfy the Code Section 6055 requirements with respect to employees covered by the multi-employer plan; the administrator of the multi-employer plan is obligated to satisfy the Code Section 6055 requirements with respect to employees of employees covered by the multi-employer plan. Caution: Don't confuse multi-employer plan with a "MEWA". In the latter situation, each employer who participates in a self-insured MEWA retains the Code section 6055 reporting obligation.
- *All* individuals covered under the plan for at least one day during the year must be identified, including but not limited to current employees, former employees, *and dependents*. Unlike the Code Section 6056 requirements, the Code Section 6055 requirements extend beyond employees who qualify as full-time. It applies to any individual covered under the plan. Caution: employers are generally required to provide the dependent's social security number; however, there is a specific process whereby the employer is able to use the dependent's date of birth if the employer who follows the process is unable to obtain the social security number.
- Employers who sponsor self-insured plans and are also ALEs will satisfy their Section 6055 and 6056 obligations on the same form—the 1095-C. Caution: IRS has informally indicated that the employer may have to report coverage elected by a former employee (and his/her family members) and any independent contractors on the 1095-B as opposed to the 1095-C.

- *2014 Health Insurance Reforms.* Various health insurance reforms were added by the ACA to Section 27 of the Public Health Service Act (and also ERISA Section 715 and Code Section 9815). The reforms apply to *all* group health plans other than plans that provide only "excepted benefits" or plans that have less than 2 active employees participating in the plan on the first day of the plan year ("stand alone retiree plan"). Although some of the reforms went into effect for plan years beginning on or after September 23, 2010, some went into effect for plan years beginning on or after January 1, 2014. Two of the 2014 reforms received the bulk of attention from the agencies during the year: the waiting period limitation and out of pocket maximum requirements:

  - The Agencies issued final regulations under PHSA Section 2708, which generally limits waiting periods for otherwise eligible individuals to 90 calendar days. The regulations clarify that terms of eligibility generally cannot be based solely on the passage of time (e.g. continuous days of employment) but that eligibility based on accumulated hours

(not to exceed 1200) or a "measurement period" are permissible. Additional regulations issued by the Agencies in 2014 further clarify that employers may implement a 30 day "orientation" period for an employee who otherwise satisfies the eligibility requirement after which the waiting period can begin.

- The agencies also issued a series of FAQs (FAQs XIX and XXI) addressing the application of the out of pocket requirements for "reference based pricing arrangements". Generally, the out of pocket maximum imposed by the ACA applies to all cost sharing with respect to services or treatments provided by network providers; cost sharing for out of network providers do not have to be applied to the out of pocket maximum. The Agencies attempted to clarify the application of the out of pocket rules to reference based pricing arrangement. Generally, reference based pricing arrangements identify an amount that will be paid or allowed by the plan with respect to a particular service or treatment. According to the FAQs, plans may treat providers who accept the plan's reference based pricing as the only network providers provided certain conditions are satisfied. If the conditions are satisfied, then all services or treatments provided by providers who do not accept the plan's reference based pricing—including "network providers" can be treated as out of network and the cost sharing for such services falls outside the out of pocket maximum limitation.

- *Employer's Payment or Reimbursement of Individual Market Coverage:* Following on the heels of guidance issued in 2013 (e.g. 2013-54), the agencies issued FAQs in 2014 (FAQs XXII) that confirm what many already knew: it is a violation of PHSA Section 2711's prohibition against annual dollar limits on essential health benefits for an employer to pay or reimburse an employee's premiums for major medical coverage purchased in the individual market, including the Marketplace. This is true whether the reimbursement is tax free under Code Section 106 or taxable. Caution: Employers who condition the taxable payment on receiving coverage would run afoul of the rules. In order to avoid running afoul of the DOL safe harbor, employers could only give employees taxable dollars and hope that they enroll in coverage. The agencies further clarified that plans that attempt to offer unhealthy individuals a choice between coverage under the plan or additional taxable cash would violate HIPAA's non-discrimination provisions.

- *New Preventive Care Requirements:* The agencies issued a FAQ in 2014 regarding the scope of smoking cessation coverage that the Agencies believe a non-grandfathered plan must provide to satisfy the preventive care requirements in PHSA section 2713. See FAQs XX and XXI. In addition, a number of new preventive care requirements go into effect for plan years beginning in 2014 and 2015. NOTE: a new or revised recommended preventive service or treatment goes into effect with the plan year that begins at least 1 year after the date the recommendation is issued. Moreover, recommendations issued in a month are considered issued on the last day of

that month. Thus, a recommendation issued in June 2013 would apply to plans for plan years beginning on or after July 1, 2014.[1]

- *Hobby Lobby Contraception Case:* In 2014, the Supreme Court ruled that the ACA's requirement for non-grandfathered plans to cover certain contraceptives violated the 1st amendment rights of for-profit corporations established and maintained based on religious beliefs that are inconsistent with such requirements. The Agencies subsequently established processes whereby such corporations would be exempt from the contraceptive coverage requirements.

- *Transitional Reinsurance Fee Registration and Payment:* The ACA added the transitional reinsurance fee to assist insurers offering coverage in the Marketplace with absorbing the additional costs associated with high risk claimants. Self-insured health group plans and insurance carriers that provide coverage for fully insured plans are responsible for paying this annual fee for 2014, 2015 and 2016. Registration for payment was initially required by November 17th (first weekday after November 15th), 2014; however, on November 14th CMS announced a delay until December 5th for reinsurance fee registration. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html. The total payment for 2014 is $63.00 multiplied by the average number of covered lives during the first three quarters of the year; however, the payment consists of two components: a component for reinsurance and another for the general Treasury fund. Each component is due on separate dates. The reinsurance component of the fee is $52.50 multiplied by the average number of covered lives and it is due no later than January 15, 2015. The Treasury component is $10.50 multiplied by the average number of covered lives and it is a due by November 15, 2015. Although plans and carriers may choose to pay the fee in two installments, they may also choose to pay the entire fee by the January 15th deadline if desired. NOTE: HHS has already indicated that the total fee due for 2015 is $44.00 and the total fee for 2016 is $27.50.

  In addition, HHS issued regulations this year that clarified critical aspects of the requirements, such as:

  - Plans and insurers need only count individuals covered by major medical plans that provide minimum value.
  - Individuals covered by plans that are secondary to other primary plans also do not have to be counted (e.g. a spouse who is also covered by the spouse's employer's plan).

- *Health Plan Identifier Number:* The ACA also required health plans with annual receipts of more than $5 million to obtain a health plan identifier number ("HPID"). Regulations originally issued by HHS required plans with at least 5 million in gross receipts to obtain the HPID by November 5, 2014 and all other health plans to obtain the HPID by November 5, 2015. However, on October

[1] See www.uspreventiveservicetaskforce.org/uspstf/uspsabrecs.htm for a list of the U.S. Preventive Services Task Force A&B recommendations and their release dates.

31st, 2014, CMS announced that it is suspending enforcement of the HIPAA HPID requirement until further notice. The following statement is on the CMS website at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html. Caution: The impact of this delay on HIPAA's EDI certification requirements (late in 2015) is currently not clear.

- *Revised PCORI Fee:* Another fee added by the ACA was the Patient Centered Outcomes and Research Institute (PCORI) fee. The fee is imposed on health insurance issuers that insure group health coverage and sponsors of self-insured group health plans. The fee was first payable for plan years ending on or after October 1, 2013 and will be payable for each plan year thereafter that ends on or before October 1, 2019. The IRS issued guidance in 2014 indicating that the PCORI fee due for plan years ending on or after October 1,2014 and prior to October 1, 2015 is $2.08 (up from $2.00). NOTE: Don't forget that the PCORI fee is due by July 31 following the plan year for which the payment is due.

- *Minimum value rules for plans that don't provide hospital coverage*: The IRS issued Notice 2014-69, which closed the loophole that allowed group health plans that do not provide substantial inpatient and/or physician care to qualify as minimum value coverage. If there was a binding written commitment prior to November 4 to offer the plan, or enrollment had already started, and the plan year began on or before March 1, 2015, the plan would continue to be treated as providing minimum value (according to the MV calculator or an actuary) for 4980H purposes (and only 4980H purposes) until the end of the plan year in which the final regulations are issued (expected to be in early 2015). Otherwise, such a plan would qualify as providing minimum value only until such date as the final regulations are issued. Notwithstanding the treatment of such plans for 4980H purposes, such plans will not be treated as providing minimum value for purposes of an individual's eligibility for a premium subsidy or tax credit in the Marketplace. Caution: If communications have already been provided that such plans will disqualify an individual from receiving a subsidy, additional communications are required to clarify the treatment of such coverage for purposes premium tax/subsidy eligibility.

- *Excepted Benefits*: Certain benefits are exempt from many of the Affordable Care Act requirements, including but not limited to the health insurance reforms. On October 1st the Agencies issued regulations this year that clarified the excepted benefit status of certain benefits such and dental and vision plans. The regulations also prescribe the rules for employee assistance plans to qualify as an excepted benefits. More specifically:
    - Dental and Vision Plans qualify as excepted benefits if
        - participants in an employer's primary health-care plan are allowed to decline the benefits OR
        - the claims for the benefits are administered under a separate contract from claims administration for any other (presumably health) benefits under the plan.

- Employee Assistance Plans (EAPs) qualify as excepted benefits if
  - The EAP doesn't provide significant benefits in the nature of medical care,
  - The benefits can't be coordinated with the benefits under another group health plan,
  - No employee contributions are required as a condition of participation, and
  - The EAP imposes no cost sharing requirements.

Cafeteria Plans

The IRS issued guidance in 2014 regarding several aspects of cafeteria plan administration (some of which is ACA driven), including:

- *2 new permissible election changes:* The IRS issued Notice 2014-55, which creates two new permissible election changes. According to Notice 2014-55, cafeteria plans are allowed, but not required, to permit plan participants to revoke their group health plan coverage and elect other minimum essential coverage in the following situations:
  - An employee who was expected to average 30 hours of service or more per month experiences an employment status change such that the employee is no longer expected to average 30 hours or more each month but does not otherwise lose eligibility under a group health plan that provides minimum essential coverage.
  - An employee is eligible to enroll in a Qualified Health Plan offered in the Marketplace (i.e., "Exchange") during the Marketplace's special or annual election period.

  Plans that wish to permit these election changes must amend their plan by December 31, 2015, or if later, the end of the plan year in which the changes are allowed. Employers who permit these election changes must notify participants of the new election change provision in order for the amendment to be effective.

- *Pay and Chase Procedures:* A Chief Counsel's Memorandum (CCM) issued in 2014 clarified the procedures required to chase overpayments of Health FSA. The CCM also clarified that failure to recover the overpayment results in income to the participant that must be reported on a W-2.

- *Impact of Carryover on HSA eligibility:* A second CCM issued in 2014 clarifies the impact Health FSA carry overs have on HSA eligibility. The CCM also provides options for plans that are designed to facilitate HSA eligibility despite the existence of a carryover (e.g. employee may choose to opt out or can convert to a limited purpose carry over if employer otherwise has a limited purpose Health FSA).

- *Deadline to amend plans to add carryover:* Employers that added a carryover provision to their Health FSA for 2014 have until the end of the 2014 to officially amend their plans to add the carryover.

Mental Health Parity and Addiction Equity Act

The final regulations under the Mental Health Parity and Addiction Equity Act ("MHPAEA") became effective for plan years beginning on or after July 1, 2014. The final regulations made a number of clarifications regarding the application of the MHPAEA, including but not limited to the application of the rules to non-quantitative treatment limitations.

The agencies also issued several FAQs (see FAQs XVII and XVIII) and an overhauled self-compliance tool in 2014.

ADA and GINA

In 2014, the EEOC made news when it sued Honeywell with respect to its wellness program. The EEOC claims that Honeywell's wellness program violates both the ADA and GINA. Honeywell's wellness program imposes premium surcharges for employees and spouses who fail to complete the biometric screen and/or who use tobacco. The EEOC claims that imposing a penalty on employees for failing to complete the screening violates the ADA's prohibition against "involuntary" post hire medical inquiries. The EEOC further claims that imposing penalties for failure to provide a spouse's information is a violation of GINA's prohibition against requesting a family member's medical history. The EEOC requested a temporary restraining order from the District Court, which was denied. It remains to be seen how this case will come out.

Transit Guidance

The IRS issued Rev. Rul. 2014-32, which addresses the use of smart cards and other electronic media as "fare media" for transit passes.

Cost of Living Adjustments

Attached as Appendix A is a list of the cost of living adjustments issued this year for next year.

Appendix A- Cost-of-living Adjustments for 2015.

High-Deductible Plans	
Annual Deductible (self-only)	$1,300
Annual Deductible (family)	$2,600
Out-of-pocket maximum (self-only)	$6,450
Out-of-pocket maximum (family)	$12,900
Health Savings Accounts	
HSA Contribution (self-only)	$3,350
HSA Contribution (family)	$6,650
Traditional Plans	
Out-of-pocket maximum (self-only)	$6,600
Out-of-pocket maximum (family)	$13,200
Flexible Spending Accounts	
FSA Contribution	$2,550
Transportation	
Transportation in a commuter highway vehicle/transit pass (monthly)	$130
Qualified parking (monthly)	$250
IRAS	
IRA Contribution Limit	$5,500
IRA Catch-Up Contributions	$1,000
IRA AGI Deduction Phase-out starting at	
Joint Return	$98,000
Single or Head of Household	$61,000
SEP	
SEP Minimum Compensation	$600
SEP Maximum Contribution	$53,000
SEP Maximum Compensation	$265,000
SIMPLE Plans	
SIMPLE Maximum Contributions	$12,500
Catch-up Contributions	$3,000
401(k), 403(b), Profit-Sharing Plans, etc.	
Annual Compensation	$265,000
Elective Deferrals	$18,000
Catch-Up Contributions	$6,000
Defined Contribution Limits	$53,000
ESOP Limits	$1,070,000 $210,000

Other	
HCE Threshold	$120,000
Defined Benefit Limits	$210,000
Key Employee	$170,000
457 Elective Deferrals	$18,000
Control Employee (board member or officer)	$105,000
Control Employee (compensation-based)	$215,000
Taxable Wage Base	$118,500

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Employee Benefits & Executive Compensation ADVISORY ■

OCTOBER 31, 2014

November 15th Deadline Quickly Approaching on ACA Transitional Reinsurance Fee

This is an updated advisory discussing new guidance on the transitional reinsurance fee. Please note that guidance is frequently issued in this area. This advisory is up-to-date as of the date of publication, but follow-up guidance from CMS may supersede the information below.

The deadline for submitting the required information and scheduling the required payment, which must be done through Pay.gov, is **November 15, 2014**.

Transitional Reinsurance Program: An Overview

The Affordable Care Act (ACA) provides for a transitional reinsurance program to help stabilize premiums for coverage in the individual health insurance market during the first three years of operation of the Health Insurance Marketplaces (2014–2016). The program is designed primarily to transfer funds from the group market to the individual market, where high risk individuals are more likely to be covered.

Payments to individual market insurers under the reinsurance program are funded by "contributions" (referred to in this advisory as "fees") payable by health insurance issuers and third-party administrators on behalf of self-insured group health plans. However, under the regulations, self-insured group health plans are ultimately responsible for the payment. Under the statute, a total of $25 billion will be collected for the three-year period from 2014–2016, $20 billion of which will be used to fund the reinsurance program and $5 billion of which will be paid into the general funds of the U.S. Treasury. In addition to these statutory amounts, states may impose additional contribution requirements to fund administrative expenses associated with the reinsurance program and/or to provide for additional reinsurance payments. Each state decides whether to establish a reinsurance program or whether to have the Centers for Medicare and Medicaid Services (CMS) administer the reinsurance program for the state.

See our previous advisory[1] for more background about the transitional reinsurance program.

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[1] "Health Care Reform Update: Final Regulations Impose Reinsurance 'Contribution' on Fully Insured and Self-Insured Plans Starting in 2014," March 28, 2012, available at http://www.alston.com/files/publication/3809b9de-2da1-4904-9e80-4fd034fc9a62/presentation/publicationattachment/a6c2cd4d-3e55-4642-b740-50081175b13f/12-196%20reinsurance%20fee.pdf.

Guidance Background

Final regulations regarding the reinsurance program were initially published by CMS on March 16, 2012.[2] These initial regulations have since been supplemented and modified on numerous occasions.[3] Current regulations may be found at 45 C.F.R. § 153.400, *et seq.*

Application of the Fee to Group Health Plans

Amount of the Fee

The transitional reinsurance fee requirement applies on a per capita basis with respect to each individual covered by a plan subject to the fee (referred to here as "covered lives"). The total amount for 2014 is $63 per covered life, and decreases to $44 per covered life in 2015. The amount of the fee for 2016 has not yet been set by CMS, but it will be lower than the 2015 amount, reflecting the lower aggregate amount required to be collected.

Group Health Plans Subject to the Requirement

The fee applies to major medical coverage, which with respect to group health plans means (1) small group health plans subject to the metal tier actuarial value requirements (generally, non-grandfathered, fully-insured plans other than excepted benefit plans), and (2) any health coverage for a broad range of services and treatments provided in various settings that provides minimum value (MV) as defined under the ACA (e.g., self-funded plans that provide MV). Below is a chart illustrating some common plans and/or arrangements and whether they are subject to the fee.

Plans That Are Subject (unless an exception applies)	Plans That Are Not Subject (*See* 45 C.F.R. § 153.400 for a complete list.)	
Major Medical Coverage	Excepted Benefits*	Health FSAs
Retiree Medical Coverage	Prescription Drug Coverage	HSAs***
COBRA Coverage	Dental and Vision Coverage**	Integrated HRAs
	Expatriate Coverage	Retiree-only HRAs
	Coverage that fails to provide minimum value	Stop-loss Coverage***
	EAP, disease management program or wellness program that does not provide major medical coverage	
	Limited exemption (2015 and 2016) for self-insured plans that do not use a TPA for certain claim functions [unlikely to apply to many plans]	

* As defined by the Public Health Service Act § 2791(c). Excepted benefits include, for example, accident and disability coverage, specified disease coverage and stand-alone dental and vision coverage.

** These plans are excluded even if they constitute essential health benefits (i.e., pediatric dental coverage).

*** Note, these arrangements are not considered group health plans.

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[2] The final regulations were published in 77 Fed. Reg. 17219 (Mar. 23, 2012) and may be found at https://federalregister.gov/a/2012-6594.

[3] HHS Notice of Benefit and Payment Parameters for 2014, 45 C.F.R. Parts 153, 155, 156, 157, and 158, 78 Fed. Reg. 15409 (Mar. 11, 2013) (https://federalregister.gov/a/2013-04902); HHS Notice of Benefit and Payment Parameters for 2015, 45 C.F.R. Parts 144, 147, 153, 155, 156, and 158, 79 Fed. Reg. 13743 (Mar. 11, 2014) (https://federalregister.gov/a/2014-05052); Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 45 C.F.R. Parts 144, 146, 147, 153, 155, and 156, 78 Fed. Reg. 65045 (Oct. 30, 2013) (https://federalregister.gov/a/2013-25326).

Who is Responsible for the Fee?

The transitional reinsurance fee is imposed on the "contributing entity," defined as an insurer for fully-insured coverage or the group health plan for self-insured coverage. Third-party administrators (TPAs), administrative service only entities (ASO) and others may submit on behalf of contributing entities, though CMS has specified that the TPA or ASO is not required by law to do so.

Practice Pointer. Because the fee is imposed on the self-insured *plan*, not the *plan sponsor*, plan assets may be used to pay the assessment. The Internal Revenue Service has also noted that plan sponsors can treat the fee as an ordinary and necessary business expense for tax purposes (i.e., deductibility[4]).

Many plans allow employees to choose a single benefit option from an array of benefit options, some of which are self-funded and some of which are fully insured (e.g., several self-funded options with a fully-insured HMO). In that situation, if each option separately provides major medical coverage, then the insurer would be responsible for the fee with respect to covered lives under the insured benefit options, and the plan would be responsible for the fee with respect to covered lives under the self-insured benefit options.

There also may be situations where a plan is partially self-funded and partially fully insured and where different plans of the same sponsor together provide major medical coverage. The regulations contain rules to address these situations, including determining what entity is responsible for the fee and the counting rules that are available. Special rules also apply if a plan changes from self-funded to fully insured (or vice versa) in the middle of a calendar year.

Finally, plans are not required to count individuals primarily residing in a U.S. territory not subject to the transitional reinsurance program and may exclude Medicare-eligible individuals *if Medicare pays primary to the plan* with respect to such individuals.

How Do I Count Covered Lives?

The term "covered lives" includes everyone covered under the plan or policy, e.g., spouses, dependents and retirees. Because the fee is based on the number of covered lives under the plan, it is important to pay careful attention to the permissible counting methods.

Overview

CMS has enumerated several options for counting covered lives, depending on whether the plan is insured or self-funded. The methods of counting covered lives for the reinsurance fee are similar to, but not exactly the same as, the Patient-Centered Outcomes Research Institute (PCORI) count methods; thus, plans should not rely on the PCORI methods for purposes of the reinsurance fee.[5] Plans may choose any applicable method, but the same method must be used for a benefit year (and across all plans). Note that the counting method does not need to be the same one the plan used for the PCORI fee. The counting period is generally the first nine months of the calendar year (except for the Form 5500 method), regardless of the plan year.

A brief description of the counting methods is below, and helpful guidance on the methods for counting can be found here.[6]

Practice Pointer. The enrollee counting rules are technical and can be very complicated. While TPAs can pull enrollment counts for the fee submission, employers should consult counsel if they have any questions about the application of the rules to their specific plan(s).

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4 http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs.

5 *See* 45 C.F.R. 153.405(d)– 45 CFR 153.405(g).

6 Centers for Medicare and Medicaid Services, *The Transitional Reinsurance Program Operational Guidance: Counting Method Examples for Contributing Entities* (July 17, 2014), available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/Examples-of-Counting-Methods-for-Contributing-Entities.pdf.

Options Available to Insured Plans

- ***Actual method:*** Add the total number of covered lives for each day of the first nine months of the benefit year, then divide that total by the number of days in those nine months.
- ***Snapshot count method:*** Add the total number of covered lives on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the year (for example, January, April and July), then divide that by the number of dates on which a count was made. Note that the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter.
- ***Member months/state form method:*** Multiply the average number of policies in effect for the first nine months of the benefit year by the ratio of covered lives per policy in effect, calculated using the prior NAIC exhibit or a form with the issuer's state of domicile.

Options Available to Self-Insured Plans

- ***Actual method:*** Add the total number of covered lives for each day of the first nine months of the benefit year, then divide that total by the number of days in those nine months.
- ***Snapshot count and snapshot factor method:***
  - ***Count:*** Add the total number of covered lives on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the year (for example, January, April and July), then divide that by the number of dates on which a count was made. Note that the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter.
  - ***Factor:*** Add the total number of covered lives on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year (for example, January, April and July), divided by the number of dates on which a count was made (note that the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter). Then, add the number of participants with self-only coverage and the product of the number of participants with coverage other than self-only coverage and a factor of 2.35.
- ***Form 5500 method:*** For a plan offering more than self-only coverage (i.e., dependent or spousal coverage), add the number of participants at the beginning and end of the plan year from the most current Form 5500 (lines 5 and 6a–6c). For a plan offering self-only coverage, perform the same calculation, but divide this number by two.

Practice Pointer. The choice of counting method may have a significant impact on the number of covered lives and the fee owed. For example, if a plan uses a wrap plan document and files a single Form 5500 for a plan that includes multiple health and welfare benefits, using the Form 5500 method to estimate the number of covered lives may significantly increase the number of covered lives (and thus, the fee). For example, if all employees receive employer-provided basic life coverage, the number of participants would include all employees, not just those enrolled in medical coverage. Please contact us if you would like assistance in choosing a method that minimizes the fee.

Necessary Documentation

Regardless of the method chosen, plans must maintain documentation of the count, including all materials provided by TPAs in arriving at this figure, for at least 10 years. CMS may audit a plan to assess its compliance with the program requirements, and it will be crucial to be able to produce this information.

Submitting the Fee

Form Submission Process

The entire reinsurance fee process takes place on Pay.gov. This process is separate from the Health Insurance Oversight System (HIOS) which is used, for example, to obtain a Health Plan Identifier (HPID). The applicable form became available on October 24, 2014. While this leaves somewhat limited time for plan sponsors to submit the applicable form and schedule the fee by the November 15, 2014, deadline, CMS has issued no guidance indicating that the submission date will be delayed. Thus, plan sponsors should act quickly to ensure compliance by the deadline.

In order to successfully complete the reinsurance fee submission, plan sponsors (or their representatives) need to:

- Register on Pay.gov;
- Fill out the Transitional Reinsurance Form;
- Attach a supporting documentation file; and
- Schedule a reinsurance payment.

More information about these steps is discussed in detail below. A helpful guide for the submission process is available here.[7]

Form

After registering on Pay.gov, the submitter will select the Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form. The form requires basic company and contact information, payment type, benefit year and the annual enrollment count (calculated using one of the methods above).

Supporting Documentation

After the information is entered into the form, plan sponsors will need to upload a Supporting Documentation CSV file. This file must contain certain company information, the annual enrollment count and the benefit year; in addition, certain technical requirements (such as file size and a prohibition on special characters) apply. CMS's Job Aid allows companies to create and error-test the file in advance.[8]

Payment

After the enrollment and supporting documentation information is submitted, the form will auto-calculate the amount owed by multiplying the required amount by the number of covered lives. Plans then need to schedule payment(s) for this amount; the form cannot be submitted without payment information. Plans can choose to remit payment for the entire benefit year at once (the full $63 per covered life), or plans can submit two separate payments for the year. If the separate payment method is used, the first payment ($52.50 per covered life) is due by January 15, 2015, and the second payment ($10.50 per covered life) is due by November 15, 2015. Plans may choose to schedule earlier payments. CMS suggests leaving 30 days between the form submission and payment date—i.e., an early December 2014 payment date for plans wishing to pay earlier than January 15, 2015. Regardless of the option chosen, the **payments MUST be scheduled by November 15, 2014**. Note that if a plan chooses to submit two payments, the plan must submit the same form and supporting documentation (with the same information) twice.

An automated clearinghouse (ACH) payment is currently the only accepted payment method, although CMS may send an invoice if there are problems with payment. Plans need to add a particular ALC+2 value (according to CMS guidance, "7505008015") with the applicable bank to ensure the payment is processed correctly; the company name for ACH purposes is "USDEPTHHSCMS."

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[7] Centers for Medicare and Medicaid Services, *ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form Manual* (Oct. 20, 2014), available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RIC_FormManual_102014_v1.pdf

[8] The file, and associated manual, are available on Regtap and at this link: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html.

Finally, plans can only include one bank account per form, so make sure to choose an account with a large enough balance for the fee.

What Should Plans Do to Prepare Before Submitting the Form and Supporting Documentation?

The actual submission process will be smoother if plan sponsors are prepared with the necessary information. To prepare for this process, plan sponsors should:

- Collect relevant information;
- Count covered lives (*remember, the method chosen can affect the amount of the fee*);
- Prepare a CSV file; and
- Notify the bank of the applicable ALC+2 value.

Enforcement

In response to questions about how the fee will be enforced, CMS issued an FAQ stating that reinsurance contributions are considered federal funds and are thus subject to the False Claims Act. The FAQ also referred to regulations stating that, with respect to health insurance issuers, the fee is a determination of debt subject to federal debt collection. Although the regulations refer only to insurers and not self-funded plans, it is expected that CMS will pursue enforcement with respect to both types of plans.

If you would like to receive future *Employee Benefits & Executive Compensation Advisories* electronically, please forward your contact information to **employeebenefits.advisory@alston.com**. Be sure to put "**subscribe**" in the subject line.

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The Center for Consumer Information & Insurance Oversight

The Transitional Reinsurance Program - Reinsurance Contributions

Alert: Annual Enrollment and Contributions Submission Form Filing Extension - December 5, 2014

Overview

Section 1341 of the Affordable Care Act established a transitional reinsurance program to stabilize premiums in the individual market inside and outside of the Marketplaces. The transitional reinsurance program will collect contributions from contributing entities to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015 and 2016 benefit years.

Who Makes Contributions?

Health insurance issuers and certain self-insured group health plans offering major medical coverage that is part of a commercial book of business are contributing entities. For the purpose of reinsurance contributions, "major medical coverage" is defined in 45 CFR 153.20 as a catastrophic plan, an individual or a small group market plan subject to the actuarial value requirements under 45 CFR 156.140, or health coverage for a broad range of services and treatments provided in various settings that provides minimum value as defined in 45 CFR 156.145. A contributing entity must make reinsurance contributions on behalf of its enrollees in plans that provide "major medical coverage," as defined under 45 CFR 153.20, unless one of the exceptions provided under 45 CFR 153.400 applies to such coverage.

Although a contributing entity is responsible for the reinsurance contributions, it may elect to use a third party administrator or administrative services-only contractor for submission of enrollment data and the transfer of the reinsurance contributions.

How Does a Contributing Entity Make Reinsurance Contributions?

HHS is implementing a streamlined approach to complete the contributions process through Pay.gov. To successfully complete the reinsurance contribution process, contributing entities, or third party administrators or administrative services-only contractors on their behalf, must register on Pay.gov.

Using Pay.gov, the contributing entity (or third party administrators or administrative services-only contractors on their behalf) will access the "ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form" to enter the annual enrollment count. The ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form will auto-calculate the annual contribution amount to be remitted based on the annual enrollment count and the contributing entity will then schedule payment for the calculated reinsurance contributions on the payment page.

Key Reinsurance Contribution Deadlines for the 2014 Benefit Year

Date	Activity	Contribution Amount
October 24, 2014	ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form Available on Pay.gov	
Extended until 11:59pm on December 5, 2014	Contributing Entities Submit Annual Enrollment Count	
No later than January 15, 2015	Contributing Entities Remit First Contribution Amount (or Combined Contribution Amount)	$52.50 per covered life (if remitting first contribution amount) or $63.00 per covered life (if remitting combined contribution amount)
No later than November 15, 2015	Contributing Entities Remit Second Contribution Amount	$10.50 per covered life (if remitting second contribution amount)
	Total	$63.00 per covered life

We note that HHS will offer contributing entities the option to pay: (1) the entire 2014 benefit year contribution in one payment no later than January 15, 2015 reflecting $63.00 per covered life; or (2) in two separate payments for the 2014 benefit year, with the first remittance due by January 15, 2015 reflecting $52.50 per covered life, and the second remittance due by November 15, 2015 reflecting $10.50 per covered life.

Announcements

Annual Enrollment and Contributions Submission Form Filing Extension - December 5, 2014

We have received requests for an extension of the deadline for contributing entities to submit their 2014 enrollment counts for the transitional reinsurance program contributions under 45 CFR 153.405(b). The deadline has now been extended until 11:59 p.m. on December 5, 2014. The January 15, 2015 and November 15, 2015 payment deadlines remain the same.

Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form Availability

The ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form will be available via www.pay.gov on Friday, October 24, 2014 in time for the 2014 benefit year's annual enrollment submission deadline of November 15, 2014.

Upcoming Webinars Pertaining to the Reinsurance Contributions Submission Process

Please visit REGTAP via https://www.REGTAP.info for upcoming educational opportunities related to the reinsurance program.

Additional Resources

- Regulations & Guidance
- Educational Materials for the Reinsurance Contributions Submission Process
  - Presentations
    - Contributing Entities and Counting Methods
    - Submission of Annual Enrollment and Contributions through Pay.gov
    - Submission of Supporting Documentation through Pay.gov
    - Job Aid Preview & Updating Reinsurance Contributions Filings
  - ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form
    - Annual Enrollment and Contributions Submission Form Manual
  - Supporting Documentation Job Aid Template
    - Supporting Documentation Job Aid Manual
  - Operational Guidance Documents
    - Examples of Counting Methods for Contributing Entities
    - Supporting Documentation File Layout Requirements
- Other Resources
  - Pay.Gov
  - REGTAP
  - Email CMS Reinsurance Contributions

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Health Care ADVISORY ■

JULY 31, 2014

The Future of Premium Tax Credits in Federal Exchanges: The Implications of *Halbig* and *King*

Within just a few hours of each other on Tuesday, July 22, 2014, two federal circuit courts of appeals made headline news with conflicting decisions on a core provision of the Affordable Care Act (ACA). In the first decision, *Halbig v. Burwell*, the U.S. Court of Appeals for the District of Columbia Circuit (the "D.C. Circuit") struck a major blow against the ACA by holding that regulations allowing premium tax subsidies through Federal Exchanges are invalid and that subsidies may be provided only through Exchanges established by States. In the second decision, *King v. Burwell*, the U.S. Court of Appeals for the Fourth Circuit (the "Fourth Circuit") took the opposite approach, holding that the regulations are valid. If the D.C. Circuit's decision in *Halbig* ultimately prevails, it will have major implications for core aspects of the ACA.

This advisory discusses the rationale of each decision, the next steps in the procedural process, the policy and political reactions, and the practical implications in the event the *Halbig* decision is not overturned, including issues relating to employer penalties, Exchanges, and related provisions.

THE LITIGATION

The IRS Rule

At issue in both cases is an Internal Revenue Service (IRS) regulation (the "IRS Rule") providing that qualified persons may receive a premium subsidy if the individual is enrolled in a qualified health plan through an "Exchange."[1] The IRS Rule defines "Exchange" for this purpose as "an Exchange serving the individual market for qualified individuals…, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by [the U.S. Department of Health and Human Services]."[2] The IRS Rule interprets section 36B(b)(2) of the Internal Revenue Code[3] ("§ 36B(b)(2)"), as added by the ACA, which provides that the IRS is to calculate tax credits for premiums for qualified health plans "which were enrolled through an Exchange established by the State under

1 26 CFR § 1.36B-2(a)(1).

2 45 CFR § 1.36B-1(k), incorporating by reference the definition in 45 CFR § 155.20.

3 26 USC § 36B(b)(2).

[section] 1311 of the Patient Protection and Affordable Care Act."

The question in both cases is whether the IRS Rule is a valid interpretation of § 36B(b)(2).

Halbig v. Burwell – the D.C. Circuit

The D.C. Circuit concluded in *Halbig v. Burwell*, No. 14-5018, that the IRS Rule is invalid. While the Court was willing to accept the government's argument that a federally facilitated exchange established under section 1321 of the ACA could be said to have been established under section 1311, it rejected the idea that the statutory language would permit such an exchange to be "an Exchange *established by the State*." The D.C. Circuit, thus, struck down the IRS Rule as contrary to the statute's plain language.

In doing so, the D.C. Circuit reasoned that:

- Other provisions of the ACA state expressly that federal territories will "be treated as a State" for purposes of establishing an exchange.[4] "Congress knew how to provide that a non-State entity should be treated as if it were a State when it sets up an Exchange." Congress's failure to use similar language in the ACA with respect to the federal exchanges confirms that Congress did not intend to extend tax credits to individuals purchasing health insurance through federally established exchanges.
- The government's concerns about absurd results under other provisions of the ACA upon application of a plain-language reading of § 36B(b)(2) are not controlling.[5] Accepting, for the sake of argument, the government's position that the results of a plain meaning construction of section 36B "are odd," the Court's "inquiry into the ACA's legislative history is quite narrow:"

  > In the face of the statute's plain meaning – a federal Exchange is not an "Exchange established by the State" – we ask only whether the legislative history provides evidence that this literal meaning is "*demonstrably* at odds with the intentions" of the ACA's drafters. Unless evidence in the legislative record establishes that it is, we must hew to the statute's plain meaning, even if it compels an odd result.[6]

- Citing Chief Justice John Marshall that "'it is incumbent on those who oppose' a statute's plain meaning 'to shew an intent varying from that which the words import,'"[7] the D.C. Circuit concludes that the ACA's legislative history fails to show Congress's "precise intent."[8] Legislative history has value only when it clearly identifies Congress's intent. Here, the legislative history is silent on Section 36B(b)(2). The plain language thus prevails because, "in the absence of any contrary indications, that text is conclusive evidence of Congress's intent."[9]

The D.C. Circuit stated that it reaches its conclusion "reluctantly" because it recognizes that, "[a]t least until States that wish to can set up Exchanges, our ruling will likely have significant consequences both for the millions of individuals

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4 *Halbig v. Burwell*, No. 14-5018, slip op. at 17 (D.C. Cir. July 22, 2014) (slip opinion).

5 *Id. at* 22-30.

6 *Id* at 32 (emphasis in original).

7 *Id.* at 34, quoting *United States v. Fisher*, 6 U.S. (2 Cranch) 358, 386 (1805).

8 *Id.*at 34.

9 *Id.*at 41.

receiving tax credits through federal Exchanges and for health insurance markets more broadly."[10]

The court's opinion in *Halbig* does not discuss how the decision affects the availability of the cost-sharing reductions that are provided to qualifying persons under section 1402 of the ACA. However, the statute provides that cost-sharing reductions are not available "with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of [the Internal Revenue] Code."[11] Thus, the decision in *Halbig* would also appear to apply to cost-sharing reductions.

King v. Burwell – the Fourth Circuit

Several hours after the D.C. Circuit issued *Halbig*, the Fourth Circuit reached the exact opposite result in *King v. Burwell*, No. 14-1158. The Fourth Circuit upheld the IRS Rule by finding that § 36B(b)(2) is ambiguous and then deferring to the IRS's reading of the statutory language as a permissible exercise of agency discretion.[12] Specifically, the Fourth Circuit reasoned that:

- Other provisions of the ACA support the government's position that § 36B(b)(2) reaches federally established exchanges. Such provisions include the ACA's definitions section, which broadly defines the word "exchange" to include non-State Exchanges. Those provisions favor the government's interpretation of the ACA, though "only slightly."[13] The Court acknowledges the common sense appeal of the plaintiffs/appellants' argument. As a result, "based solely on the language and context of the most relevant statutory provisions, the court cannot say that Congress's intent is so clear and unambiguous that it 'foreclose[s] any other interpretation.'"
- Congress's intent is not rendered clear from the other relevant provisions, which the government contends conflicts with the plain language interpretation advanced by plaintiffs. Statutes of ACA's size naturally have conflicts, and the mere existence of conflicts within a statute does not render the government's view as dispositive of Congress's intent.[14]
- Nothing in the legislative history provides compelling support for either party.[15]
- While the government has the better of the statutory construction argument(s), the Court concludes that "the statute is ambiguous and subject to at least two different interpretations."[16]
- The IRS Rule is a reasonable exercise of agency judgment. Confronted with an ambiguous provision, the IRS "crafted a rule ensuring the credits' broad availability and furthering the goals of the law."[17] The IRS's exercise of discretion is entitled to deference under the second step of the *Chevron* standard.

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[10] *Id*. (noting that its conclusion is dictated by Congress's supremacy in matters of policy and that the court's duty, "when interpreting a statute is to ascertain the meaning of the words of the statute duly enacted through the formal legislative process").

[11] ACA § 1402(f)(2).

[12] *King v. Burwell,* No. 14-1158, slip op. at 5 (4th Cir. July 22, 2014).

[13] *Id.* at 20.

[14] *Id.* at 24-25.

[15] *Id. at 28.*

[16] *Id.* at 28.

[17] *Id*. at 34.

As with *Halbig*, the court's decision in *King* does not address cost-sharing reductions. However, for the reasons discussed above, the *King* decision would also appear to apply to the availability of cost-sharing reductions.

Next Steps in the Process

The government has announced that it will seek a resolution of the circuit split through an *en banc* review of the *Halbig* decision. If the D.C. Circuit grants *en banc* review on the ground that the case involves a question of exceptional importance (or involves an issue on which there is a circuit split), the government may have a reasonable likelihood of success in overturning the panel decision. This is because the Democratic appointees to the D.C. Circuit – who are more likely to look to the purpose and intent of the ACA as a whole, as opposed to taking a textualist (and plain language) approach to statutory interpretation and, thus, to uphold the IRS Rule – outnumber the Republican appointees eligible to sit *en banc* in *Halbig* seven to five.[18] Indeed, the panel in *Halbig* consisted of two Republican appointees in the majority and one Democratic appointee who dissented from the D.C. Circuit's decision.

Even if the D.C. Circuit grants *en banc* review and reverses *Halbig*, the issue remains far from settled because similar cases remain pending in other jurisdictions. Those cases include: *Association of American Physicians & Surgeons, Inc. v. Koskinen*, 14-2123 (7th Cir., appeal docketed May 20, 2014); *State of Indiana v. Internal Revenue Service*, No. 1:13-CV-1612-WTL-TAB (S.D. Ind., filed Oct 18, 2013); and *State of Oklahoma v. Sebelius*, No.6:11-CV-0030-RAW (E.D. Okla, filed January 24, 2011). The outcomes in those cases could produce decisions from the U.S. Courts of Appeals for the Seventh and Tenth Circuits.

The existence of a split among the circuits greatly increases the likelihood that the U.S. Supreme Court would grant a petition for a *writ of certiorari* and review the lower courts' interpretation of the statute. If no circuit split exists, the Supreme Court tends to take cases only when the issue is of particular importance or merits quick resolution, or if they feel the lower courts have disregarded their previous decisions.

The mandate of the D.C. Circuit in *Halbig* will not issue and, thus, the decision will not be enforceable until after the period for seeking rehearing has expired or a petition for rehearing has been decided; if a petition for *writ of certiorari* is filed with the Supreme Court, the mandate may be stayed pending disposal of the case by the Supreme Court. Until the U.S. Department of Justice exhausts its appeal of the *Halbig* decision, the Department's position is that tax credits remain available to individuals who purchased insurance through federally established exchanges. News Release, Dep't. of Justice, Office of Pub. Affairs, *Statement by Justice Dep't Spokesperson on King v. Burwell and Halbig v. Burwell*, DOJ 14-771 (July 22, 2014).

IMPLICATIONS

What exactly is a Federal Exchange?

By striking at the core of the ACA, the *Halbig* decision, if it ultimately prevails, could have a dramatic impact on the success of ACA. However, the impact may depend on the details of an issue that is not really addressed by either the *Halbig* or *King* court – what exactly is a Federal vs. a State Exchange or, more precisely, what does a State need to do to establish an Exchange? The two courts do not agree on just how many State and Federal Exchanges there are – the D.C. Circuit counts 36 Federal Exchanges, while the Fourth Circuit counts 34. The difference appears to be Idaho

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[18] The D.C. Circuit's current composition of Circuit Judges eligible for *en banc* review consists of seven Democratic appointees and four Republican appointees. Because Senior Judge A. Raymond Randolph, a Republican appointee, participated in the panel decision in *Halbig*, he may participate in a rehearing *en banc* if he so chooses. *See* United States Court of Appeals for the District of Columbia Circuit, *Handbook of Practice and Internal Procedures*, 57 (Nov. 12, 2013).

and New Mexico, which have State Exchanges, although enrollment takes place through www.healthcare.gov. Under *Halbig*, there may be a more thorough re-examination of just what a State needs to do in order to be considered to have established an Exchange.

Implications for Individuals, Exchanges and the Delivery System

Regardless of a State's Exchange status, a final resolution that denies premium subsidies to even part of the population otherwise eligible for them would not only impact individual consumers, who may choose to forgo coverage in the absence of financial support, but also threatens the viability of the broader Exchange marketplace.[19] A well-functioning Exchange marketplace requires a risk pool that reflects a full range of consumer demographics. If healthy or younger individuals opt out of the ACA's coverage options, premium and participation costs may increase for others, and Exchanges themselves may fail to function efficiently.

Health care providers, and hospitals in particular, may also be impacted by an affirmation of the *Halbig* decision. The ACA effects a reduction in federal financial support for uncompensated care (e.g., reductions in federal disproportionate share hospital (DSH) payments) because it anticipated an increase in the number of people covered by health insurance or Medicaid. Hospitals – especially in States electing not to expand their Medicaid programs and not to create Exchanges – may find that they are responsible for substantially more uninsured individuals than promised by the ACA, further weakening an already fragile safety net system in some communities.

Implications for Employers

The *Halbig* decision impacts potential liability under the employer responsibility provisions of the ACA, also known as the "pay or play" penalties, imposed under Internal Revenue Code (the "Code") section 4980H. The penalties are triggered if a full-time employee receives a premium tax subsidy ("Premium Subsidy").[20] Because Premium Subsidies are accessed by individuals through Exchanges based on place of residence (rather than where they work), *Halbig* means that employers could face different exposure to penalties based on where their employees live and whether there is a Federal Exchange or a State Exchange in the employee's State of residence. The employer penalties generally apply starting in 2015.[21]

Overview of Employer Penalties

The employer penalties apply to "applicable large employers" (ALEs), meaning employers with at least 50 full-time equivalent employees.[22] In the case of employers that are members of a controlled group of entities, whether an employer is an ALE is determined by looking at the entire controlled group; however, liability for any penalties is determined separately for each applicable large employer member (ALEM), *i.e.*, each separate employer that comprises the ALE.

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19 The D.C. Circuit itself recognizes the potential impact of its decision on health insurance markets. *See Supra* note 10.

20 Note that the penalties are triggered if a full-time employee receives either a premium tax subsidy or a cost-sharing reduction (under ACA § 1402). As discussed above in the text, a condition to receiving a cost-sharing reduction is qualification for a premium subsidy. For convenience, the term "Premium Subsidy" in this section refers to both the premium tax credit under Code § 36B and cost-sharing reductions.

21 The statute provides that the penalties are effective starting in 2014; Treasury Regulations provide a one-year delay.

22 Under a transition rule, the 50 full-time equivalent employee threshold is increased to 100 full-time equivalent employees in 2015 for employers that satisfy certain requirements.

Generally, Code Section 4980H imposes penalties on ALEMs for any month during a calendar year in which one or more of the employer's full-time employees are certified as having received a Premium Subsidy and if either of the following applies:

- The ALEM failed to offer minimum essential coverage (MEC) during that month to substantially all[23] of its full-time employees and their dependent children (including adult dependent children up to age 26).[24] In this case, the employer would be liable for what we refer to as the Sledgehammer Penalty (sometimes called the "fail to offer" or "4980H(a)" penalty) if even one full-time employee receives a Premium Subsidy; OR
- The ALEM offered minimum essential coverage to substantially all its full-time employees (and their dependents) during that month but the coverage was not affordable or didn't provide minimum value. In this case, the employer would be liable for what we refer to as the Tackhammer Penalty (sometimes referred to as the "nonqualified coverage" or "4980H(b)" penalty) with respect to full-time employees who receive a Premium Subsidy.[25]

As a practical matter, the Sledgehammer Penalty will typically be much greater than the Tackhammer Penalty, because, if triggered, it is based on the total number of the ALEM's full-time employees, whereas the Tackhammer penalty is limited to the number of full-time employees who receive Premium Subsidies. As a result, many employers have focused planning on at least avoiding the Sledgehammer Penalty. The penalties are calculated as follows:

- The Sledgehammer Penalty for any month is equal to the product of one-twelfth of $2,000 ($167) multiplied by all of the ALEMs full-time employees (reduced by its allocable share of a de minimis amount).
- The Tackhammer Penalty for any month is equal to the product of one-twelfth of $3,000 ($250) multiplied by the number of full-time employees who received a Premium Subsidy during that month, or if less, the maximum amount of the Sledgehammer Penalty.

Effect of Halbig

Because the employer penalties are triggered only if a full-time employee receives a Premium Subsidy, the decision in *Halbig*, if controlling, would have a direct impact on potential employer liabilities. The impact will vary based on the residence of the employer's employees. The following general examples illustrate the potential impact if the rationale of the *Halbig* decision is controlling.

For example, if all of an ALEM's employees reside in States that have not established Exchanges, then that employer would not be subject to a penalty, even if the employer does not offer coverage to any full-time employee (and their dependent children).

As another example, suppose an ALEM has employees who reside in Nevada (which has established an Exchange) and Texas (which has a federally facilitated exchange) and that the ALEM does not offer coverage to substantially all its full-time employees (and dependent children). Employees who reside in Texas cannot trigger the penalties under *Halbig*, because the Premium Subsidies are not available. However, if one of the full-time employees who resides in Nevada receives a Premium Subsidy, then the Sledgehammer Penalty would apply and would be calculated based

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[23] Under an administrative transition rule, "substantially all" means 70% for 2015 and 95% in 2016 and later years.

[24] Under another administrative transition rule, certain plans that did not historically offer coverage to dependent children may have until 2016 to provide such coverage without incurring a penalty.

[25] Even if the ALEM was not subject to the Sledgehammer Penalty because it offered MEC to substantially all full-time employees (and dependent children), the Tackhammer Penalty would still be assessed for any full-time employee who receives a Premium Subsidy because the ALEM did not offer that employee coverage.

on the total number of the ALEM's full-time employees, including those who reside in Nevada and those that reside in Texas. Note that the Sledgehammer penalty would apply even if only one full-time employee in Nevada receives a Premium Subsidy. On the other hand, the Tackhammer penalty would only apply with respect to employees who reside in States that have established an Exchange.

Thus, in general, *Halbig* adds a new element to the analysis of whether pay or play penalties may be triggered. The ultimate impact, however, will vary from employer to employer. An employer with even a few full-time employees in States that established Exchanges can still be subject to significant penalties without appropriate planning.

CONCLUSION

Until a resolution that affirms *Halbig* is reached – a result that could take until 2015 if the U.S. Supreme Court receives and accepts a petition for *certiorari* – the Administration is unlikely to stop providing premium subsidies to those eligible for them who purchased qualified health plans through a federally facilitated exchange. And although some in Congress may seek a legislative correction that clarifies the ACA text at issue, neither the House nor the Senate appear likely to reach a consensus to secure final passage this year; the legislative environment for ACA changes is challenging and is likely to remain that way, especially in an election year.

Alston & Bird will continue to provide updates and analysis of progress in both *Halbig* and *King*, and in the related district court cases as they occur at www.alston.com

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FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXII)

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Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at http://www.dol.gov/ebsa/healthreform/ and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Compliance of Premium Reimbursement Arrangements

On September 13, 2013, DOL and the Treasury published guidance on the application of the market reforms and other provisions of the Affordable Care Act to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements.[1] HHS issued contemporaneous guidance to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in the DOL and Treasury Department guidance.[2] Subsequently, on May 13, 2014, two FAQs were made available on the IRS website addressing employer health care arrangements.[3]

The Departments' prior guidance explains that employer health care arrangements, such as HRAs and employer payment plans, are group health plans that typically consist of a promise by an employer[4] to reimburse medical expenses up to a certain amount. The Departments' guidance clarifies that such arrangements are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual limits under Public Health Service Act (PHS Act) section 2711 and the requirement to provide certain preventive services without cost sharing under PHS Act section 2713.[5] The Departments' guidance further clarifies that such

[1] See DOL Technical Release 2013-03, available at http://www.dol.gov/ebsa/newsroom/tr13-03.html, and IRS Notice 2013-54, available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf.

[2] See Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf.

[3] Available at: www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements.

[4] These arrangements may be sponsored by an employer, an employee organization, or both. For simplicity, this section of the FAQs refers to employers. However, this guidance is equally applicable to HRAs sponsored by employee organizations, or jointly by employers and employee organizations.

[5] Section 1001 of the Affordable Care Act added new PHS Act §§ 2711-2719. Section 1563 of the Affordable Care Act (as amended by Affordable Care Act § 10107(b)) added Code § 9815(a) and ERISA § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these

employer health care arrangements will not violate these market reform provisions when integrated with a group health plan that complies with such provisions. However, an employer health care arrangement cannot be integrated with individual market policies to satisfy the market reforms. Consequently, such an arrangement may be subject to penalties, including excise taxes under section 4980D of the Internal Revenue Code (Code).

Q1: My employer offers employees cash to reimburse the purchase of an individual market policy. Does this arrangement comply with the market reforms?

No. If the employer uses an arrangement that provides cash reimbursement for the purchase of an individual market policy, the employer's payment arrangement is part of a plan, fund, or other arrangement established or maintained for the purpose of providing medical care to employees, without regard to whether the employer treats the money as pre-tax or post-tax to the employee. Therefore, the arrangement is group health plan coverage within the meaning of Code section 9832(a), Employee Retirement Income Security Act (ERISA) section 733(a) and PHS Act section 2791(a), and is subject to the market reform provisions of the Affordable Care Act applicable to group health plans. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate PHS Act sections 2711 and 2713, among other provisions, which can trigger penalties such as excise taxes under section 4980D of the Code. Under the Departments' prior published guidance, the cash arrangement fails to comply with the market reforms because the cash payment cannot be integrated with an individual market policy.[6]

Q2: My employer offers employees with high claims risk a choice between enrollment in its standard group health plan or cash. Does this comply with the market reforms?

No. PHS Act section 2705,[7] which was incorporated by reference into ERISA section 715 and Code section 9815, as well as the nondiscrimination provisions of ERISA section 702 and Code section 9802 originally added by the Health Insurance Portability and Accountability Act (HIPAA), prohibit discrimination based on one or more health factors. Offering, only to employees with a high claims risk, a choice between enrollment in the standard group health plan or cash, constitutes such discrimination. While the Departments' regulations implementing this provision[8] permit more favorable rules for eligibility or reduced premiums or contributions based on an adverse health factor (sometimes referred to as benign discrimination), in the Departments' view, cash-or-coverage arrangements offered only to employees with a high claims risk are not

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referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

[6] See DOL Technical Release 2013-03, available at http://www.dol.gov/ebsa/newsroom/tr13-03.html, and IRS Notice 2013-54, available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf. See also Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf.

[7] Prior to the enactment of the Affordable Care Act, Titles I and IV of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, added section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act (HIPAA nondiscrimination and wellness provisions). Affordable Care Act section 1201 also moved those provisions in the PHS Act from section 2702 to section 2705.

[8] 26 CFR 54.9802-1 (g); 29 CFR 2590.702(g);146.121(g).

permissible benign discrimination. Accordingly, such arrangements will violate the nondiscrimination provisions, regardless of whether (1) the cash payment is treated by the employer as pre-tax or post-tax to the employee, (2) the employer is involved in the selection or purchase of any individual market product, or (3) the employee obtains any individual health insurance.

Such offers fail to qualify as benign discrimination for two reasons. First, if an employer offers a choice of additional cash or enrollment in the employer's plan to a high-claims-risk employee, the opt-out offer does not reduce the amount charged to the employee with the adverse health factor. Rather, the employer's offer of cash to a high-claims-risk employee who opts out of the employer's plan 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. For example, if the employer's group health plan requires all employees to pay $2,500 toward the cost of employee-only coverage under the plan, but the employer offers a high-claims-risk employee $10,000 in additional compensation if the employee declines the coverage, for purposes of discrimination analysis, the effective required contribution by that high-claims-risk employee for plan coverage is $12,500 – that is, the $2,500 required employee contribution for employee-only coverage under the employer's plan plus the $10,000 of additional compensation that the employee would forgo by enrolling in the plan. Because a high-claims-risk employee must effectively contribute more to participate in the group health plan, the arrangement violates the rule that a group health plan may not on the basis of a health factor require any individual (as a condition of enrollment) to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan.

Second, the Departments' regulations generally permit providing, based on an adverse health factor, enhancements to eligibility for coverage under the plan itself but not cash as an alternative to the plan. In particular, the regulations permit providing plan eligibility criteria that offer extended coverage within the plan and subsidization of the cost of coverage within the plan based on an adverse health factor.[9] An example in the Departments' regulations illustrates that a plan may have an eligibility provision that provides coverage to disabled dependent children beyond the age at which non-disabled dependent children become ineligible for coverage.[10] Another example in the regulations illustrates that a plan may provide coverage free of charge to disabled employees, while other employees pay a participant contribution towards coverage.[11] However, in the Departments' view, providing cash as an alternative to health coverage for individuals with adverse health factors is an eligibility rule that discourages participation in the group health plan. This type of arrangement differentiates based on a health factor and is outside the scope of the Departments' regulations on benign discrimination, which permit only discrimination that helps individuals with adverse health factors to participate in the health coverage being offered to other plan participants. The Departments intend to initiate rulemaking in the near future to clarify the scope of the benign discrimination provisions.

[9] 26 CFR 54.9802-1 (g)(1)(i); 29 CFR 2590.702(g)(1)(i);146.121(g)(1)(i).
[10] 26 CFR 54.9802-1 (g)(1)(ii), Example 1; 29 CFR 2590.702(g)(1)(ii), Example 1;146.121(g)(1)(ii), Example 1.
[11] 26 CFR 54.9802-1 (g)(2)(ii), Example; 29 CFR 2590.702(g)(2)(ii), Example;146.121(g)(2)(ii), Example.

Finally, because the choice between taxable cash and a tax-favored qualified benefit (the election of coverage under the group health plan) is required to be a Code section 125 cafeteria plan, imposing an effective additional cost to elect coverage under the group health plan could, depending on the facts and circumstances, also result in discrimination in favor of highly compensated individuals in violation of the Code section 125 cafeteria plan nondiscrimination rules.

Q3: A vendor markets a product to employers claiming that employers can cancel their group policies, set up a Code section 105 reimbursement plan that works with health insurance brokers or agents to help employees select individual insurance policies, and allow eligible employees to access the premium tax credits for Marketplace coverage. Is this permissible?

No. The Departments have been informed that some vendors are marketing such products. However, these arrangements are problematic for several reasons. First, the arrangements described in this Q3 are themselves group health plans and, therefore, employees participating in such arrangements are ineligible for premium tax credits (or cost-sharing reductions) for Marketplace coverage. The mere fact that the employer does not get involved with an employee's individual selection or purchase of an individual health insurance policy does not prevent the arrangement from being a group health plan. DOL guidance indicates that the existence of a group health plan is based on many facts and circumstances, including the employer's involvement in the overall scheme and the absence of an unfettered right by the employee to receive the employer contributions in cash.[12]

Second, as explained in DOL Technical Release 2013-03, IRS Notice 2013-54, and the two IRS FAQs addressing employer health care arrangements referenced earlier, such arrangements are subject to the market reform provisions of the Affordable Care Act, including the PHS Act section 2711 prohibition on annual limits and the PHS Act 2713 requirement to provide certain preventive services without cost sharing. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate PHS Act sections 2711 and 2713, among other provisions, which can trigger penalties such as excise taxes under section 4980D of the Code.

[12] See 29 CFR 2510.3-1(j).