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Complying With ACA, HIPAA Changes: Mid-Year Check for Employers

By Edward I. Leeds

Employers that sponsor or administer group health plans will face a number of important legal and regulatory requirements that take effect on or before January 1, 2015, including changes under the Affordable Care Act (ACA) and Health Insurance Portability and Accountability Act (HIPAA). As employers turn the corner toward 2015, it is a good time for them to take stock of measures they have completed and assess the measures they still need to take to comply with recent guidance. The following list addresses a number of the health plan matters that we have discussed with our clients in recent weeks.

Affordable Care Act

Courts Continue to Wrestle With ACA Implementation. In cases that could have a dramatic impact on key ACA requirements, two federal appeals courts have reached different conclusions about the availability of federal subsidies in most health insurance exchanges. The courts addressed whether federal subsidies are available in states where health insurance exchanges are operated by the federal government and not established by the state. In King v. Burwell, the Fourth Circuit Court of Appeals held that these subsidies are available (*King v. Burwell*, 2014 BL 201873, 4th Cir., No. 14-1158, 7/22/14). In Halbig v. Burwell, the D.C. Circuit Court of Appeals ruled that they are not (*Halbig v. Burwell*, 2014 BL 201816, D.C. Cir., No. 14-5018, 7/22/14).

If the judgment in *Halbig* prevails, the ACA's shared responsibility requirements would be significantly curtailed. In more than two-thirds of the states, individuals would lose their subsidies for exchange coverage. The loss of these subsidies may render health coverage unaffordable for many. If the unaffordability for an individual meets certain ACA guidelines, he or she will not be subject to the individual mandate. As a result, many individuals would not need to obtain health coverage to avoid federal penalties, but many may also find substantial health coverage too expensive to obtain.

In states with federally operated exchanges, the employer mandate would lose essentially all of its teeth. Assessments under the employer mandate apply only if at least one full-time employee obtains subsidized coverage through an exchange. In some cases, the assessments are measured by the number of full-time employees who obtain the subsidy. If there are no subsidies, there would be no assessments.

The potential loss of federal subsidies in states with federal exchanges would pose challenges for Congress (where technical correction legislation presumably will be introduced), the federal agencies responsible for administering the ACA, and state governments that have not established their own exchanges. They also present

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issues to insurers, and employers that have at least some employees in states with federally operated exchanges.

All of these issues have arisen as employers prepare for the implementation of the employer mandate in 2015. For now, it does not appear as if the federally operated exchanges will cease offering subsidies, and employers should consider how they will address the requirements of the employer mandate while paying close attention to developments in the appeal of these recent decisions.

Employer Mandate. Absent a resolution of the *Halbig* and *King* decisions that results in the elimination of federal subsidies in relevant states, most employers will need to comply with the employer mandate for health coverage under the ACA in 2015. Employers that do not offer affordable health coverage that meets prescribed standards for value to all full-time employees may be required to make a payment to the federal government. To avoid these payments, employers will need to identify which of their employees are full-time (working at least 30 hours per week) and make certain other determinations. *Final regulations* issued earlier this year address both basic rules for implementing the employer mandate and *various specific situations*.

The final rules also include certain transitional rules that may help employers comply with the mandate in 2015. Employers have already benefited from a one-year delay in the implementation of these requirements; they need to use their remaining time in 2014 to take appropriate steps to prepare for the implementation of the mandate.

Reporting. The ACA's *shared responsibility requirements* carry with them certain reporting obligations. As we went to press, the Internal Revenue Service (IRS) issued early drafts of the form that employers will need to complete to meet these obligations, but even before this, the IRS published considerable guidance on the reporting requirements arising from both the *employer mandate* and the *individual mandate*. Employers should consider how they will collect the data for 2015 that will need to be provided to individuals and the government under these new rules. Because the collection of that data may involve systems changes, it is not too early to begin this review.

Waiting Periods. Effective in 2014, the ACA limits the length of waiting periods under group health plans to 90 days. The *90-day period* may not be extended to allow coverage to begin on the first day of the next month. The waiting period limitations are not intended to supersede permissible eligibility requirements under a plan. The rules allow plans to require an employee to work a cumulative number of hours (not to exceed 1,200) before the employee becomes eligible to participate. In addition, under recently *finalized regulations*, an employer may regard this limit as beginning after an orientation period of up to one month. Employers, particularly those with high rates of employee turnover, may consider whether to refine their eligibility requirements in view of these new rules. However, employers need to keep in mind that the employer mandate may require coverage for a full-time employee before a lengthy waiting period expires.

Payment of Premiums for Individual Coverage. As the implementation of the employer mandate has drawn closer, employers have started to hear about various types of health benefit arrangements that involve the purchase of individual health insurance policies. Last year, the IRS published *a notice* that essentially prohibits its active employees from purchasing individual health insurance with pre-tax dollars. This prohibition applies whether the coverage is purchased through a cafeteria plan or through payments or reimbursements made by an employer. This notice reversed IRS guidance that had been in place for more than 50 years. Employers presented with an arrangement that involves the purchase of individual health insurance coverage will need to pay careful attention to these rules.

Health Reimbursement Accounts. The *same notice* that addresses the payment of premiums for individual coverage provides guidance on Health Reimbursement Accounts (HRAs) under the ACA. Perhaps most significantly, it sets forth two methods for integrating an HRA into a group health plan to meet the ACA's prohibition against annual and lifetime dollar limits and preventive care requirements. Both methods, for example, require the plans to allow employees to opt out of the HRA and forfeit amounts in their HRA accounts. Employers with HRAs should review how their arrangements are documented to make sure that they comply with these integration requirements.

Cost-Sharing Limits. The ACA establishes limits on the amount of out-of-pocket expenses (such as deductibles, co-payments, and co-insurance) that a plan participant will need to pay before the plan reimburses medical expenses at 100 percent. *The limits* are $6,350 and $12,700 for single and family coverage, respectively, in 2014 and will increase to $6,600 and $13,200 in 2015. *Regulations* addressing this subject clarify that network-based plans will need to meet these requirements only with respect to in-network expenses. *Other guidance* offers a one-year reprieve from the obligation to coordinate expenses that are administered by different plan vendors to meet a single unified cost-sharing limit. This reprieve applies, for example, where major medical claims are administered by a third-party administrator and prescription drug claims are administered separately by a pharmacy benefit manager. The reprieve applies only to plan years beginning in 2014. In preparation for 2015, plan sponsors that carve out the administration of certain types of benefits under their medical plans will need to make sure that plan vendors can share data appropriately to track out-of-pocket expenses against the unified cost-sharing limit (or that the sum of the cost-sharing limits for each type of benefit is low enough that coordination is not needed).

Excepted Benefits. Plans that qualify as excepted benefits will not be subject to certain ACA requirements and will not disqualify individuals from obtaining a subsidy for coverage purchased through a health insurance exchange. Under *guidance issued late last year*, excepted benefits now include:

- stand-alone dental and vision plans, whether or not employees must contribute toward their cost;
- certain employee assistance plans; and
- certain plans designed to wrap around individual coverage purchased by employees for whom the employer's medical plan is unaffordable.

Employers may consider whether they wish to take advantage of any of these new rules.

COBRA and Health Insurance Exchanges. The Department of Labor (DOL) has published revised *model Con-*

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solidated Omnibus Budget Reconciliation Act (COBRA) forms that alert individuals who are entitled to elect continuation coverage under COBRA of the alternatives that may be available through the ACA's Health Insurance Marketplace (otherwise known as the health insurance exchanges). Although this information is not strictly required to be included in COBRA notices, employers may wish to inform those considering a COBRA election about other coverage options that are available to them, potentially at a lower cost.

HIPAA

Privacy and Security. After a major effort to comply with the comprehensive privacy and security *regulations* in 2013, many plan sponsors still have work to do to finish their implementation programs. These efforts may include fine-tuning policies and procedures, completing training, and, most of all, finalizing revisions to long-standing business associate agreements before the grace period for those revisions expires on **September 23, 2014**.

Health Plan ID Numbers. It has taken the federal government a long time to implement the requirement that health plans obtain a unique identification number, but a *deadline has been set*. Larger plans (with receipts of at least $5 million) must obtain this ID number by **November 5, 2014.** Smaller plans have an additional year to obtain the ID. Although some commenters have suggested that employers wait before filing for a health plan ID number, employers will need to allow adequate *lead time* to complete the process.

Certificates of Creditable Coverage. For years, health plans have been issuing certificates of creditable coverage to individuals (mostly former plan participants) under HIPAA's portability rules. These certificates specify how long an individual has participated in the plan. Individuals have used these certificates as proof of prior coverage, which may reduce or eliminate a pre-existing condition limitation under a new health plan in accordance with HIPAA rules. With the ACA's prohibition against pre-existing condition limitations, the HIPAA portability *regulations* have been modified to delete the requirement to issue this certificate. Beginning in 2015, plan sponsors will no longer need to issue these certificates, and they may consider making appropriate changes to their administrative processes and vendor contracts.

OTHER DEVELOPMENTS

Same-Sex Marriage. Employers that have not already reviewed the definition of ''spouse'' and other relevant terms of their health and cafeteria plans following the U.S. Supreme Court's *decision* to recognize same-sex marriage may wish to do so in view of other developments. These developments include guidance issued by the *IRS* and *DOL* and the recognition of same-sex marriage in an *increasing number of states*, as well as Washington, D.C.

Subrogation/Third-Party Reimbursement. Many employers face ongoing issues with the enforcement of provisions allowing plans to recover benefit costs from third parties responsible for a participant's injury or illness. Employers that have sought to recover amounts paid from their medical (or disability) plans in these circumstances know how important the subrogation or third-party reimbursement provisions of a plan document or summary plan description (SPD) can be. The significance of these provisions was reinforced last year when the U.S. Supreme Court *upheld* a plan's specific terms providing that the plan is not responsible for paying a portion of a participant's attorneys' fees. Employers may wish to review the relevant provisions in their plan documents and SPDs.

Health FSA Carryforwards. Employers that sponsor health flexible spending arrangements (health FSAs) may consider whether they wish to allow employees to carry forward unused contributions from one year to the next. An *IRS notice* issued last year allows for these carryforwards up to $500. This notice required employers to choose between this new carryforward opportunity and the two-and-a-half-month grace period that many employers implemented to allow an employee additional time to incur expenses that could be applied against his or her account. More recent *guidance* describes how to address carryforwards for a participant who enrolls in a high deductible health plan with a health savings account, given that any amount in a general purpose health FSA would preclude the participant from making or receiving health savings account contributions.

Religious Freedom Restoration Act. In a very recent *decision* , the U.S. Supreme Court ruled that the Religious Freedom Restoration Act protected three closely held for-profit corporations from the requirement to cover certain forms of contraception that was developed under the preventive care provisions of the Affordable Care Act. The scope of this ruling may be tested in future years.