



## **Track 3 – Session 6**

# **Employee Benefits Update – The Effect of the Affordable Care Act on Employee Benefits Programs**

*Julie A. Lewis  
Nowlan & Mouat LLP, Janesville*

State Bar of Wisconsin  
Health, Labor and Employment Law Institute

Employee Benefits: The New Landscape

*presented by*  
*Julie A. Lewis, Nowlan & Mouat LLP*

The Affordable Care Act's Effect  
on Employee Benefit Plans - 2015

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In passing the Affordable Care Act, Congress selected employer-sponsored group health insurance as the vehicle for paying medical costs of the uninsured.

The ACA changed the benefits landscape by mandating coverage for certain essential health benefits that were previously optional, requiring coverage for pre-existing conditions and restricting insurers' ability to community rate premiums.

In this new environment, what are the options for employers, benefits advisors, insurers and employees?

What steps can employers take to offer the most complete range of medical benefits supported by tax and insurance-optimized payment alternatives?

This presentation reviews IRS 2014 and 2015 regulatory guidance regarding:

- Customized coverage
- Optimized payment arrangements
- 2015 employer reporting requirements

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*Customized Coverage*

Excepted benefits in theory –

Certain health care-related benefits are excluded from ACA requirements. They include:

- Benefits that are not health coverage but may provide payment for health coverage
  - Auto insurance, liability insurance, worker's compensation and AD&D policies

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*Customized Coverage*

Excepted benefits in theory –

- Limited excepted benefits
  - Limited scope vision and dental benefits
  - Benefits for long term care, nursing home care, home health care and health FSAs
  - To be excepted from ACA requirements, these benefits must be either (1) provided under a separate policy or certificate, or (2) otherwise not an integrated part of a group health insurance plan.

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*Customized Coverage*

Excepted benefits in theory –

- Non-coordinated excepted benefits
  - Coverage for a specific illness or injury (“cancer-only” policies)
  - Hospital indemnity or other fixed indemnity coverage
  - The benefits are excepted if (1) they are offered under a separate policy or certificate, (2) there is no coordination with the employer’s primary group health plan, and (3) benefits are paid without regard to redundant (primary) coverage.

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*Customized Coverage*

Excepted benefits in theory –

- Supplemental excepted benefits
  - Supplemental Medicare, TRICARE and other veterans’ coverage or similar supplemental or gap coverage offered under a separate policy or certificate

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*Customized Coverage*

Excepted benefits in practice –

- Voluntary benefits
  - Employers are customizing an internal benefits “marketplace” to include employer-sponsored vision, dental, long-term care, nursing home care and home health care plans that are offered at a group rate.
  - Dental and vision plans are being spun off from integrated group health insurance plans to stand-alone plans to avoid the ACA’s annual benefit maximums and to reduce the group health plan value in anticipation of the high value excise (“Cadillac”) tax.

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*Customized Coverage*

Excepted benefits in practice –

- Voluntary benefits
  - Health flexible spending accounts (Health care FSAs) have traditionally been an excepted benefit but the rules have been tightened.
    - Health care FSAs must be part of a Section 125 plan.
    - The participant’s salary reduction cannot exceed the greater of two times the salary reduction amount or the salary reduction amount plus \$500.

A health care FSA that is not excepted from the ACA could trigger the \$100/day excise tax.

*Customized Coverage*

Excepted benefits in practice –

- Limited wraparound coverage
  - Employees who are not entitled to ACA mandated coverage (e.g., part-time and retired employees) can purchase employer-sponsored limited wraparound coverage to pay for benefits they do not receive through their Healthcare.gov individual plan.
  - Limited wraparound coverage might include coverage beyond EHB for in-network medical clinics or providers, the cost of prescription drugs not covered by the primary plan, home health care coverage or access to an employer's on site clinic at no cost.
  - Annual cost of limited wraparound coverage per employee and covered dependents cannot exceed the maximum annual FSA contribution or 15% of the primary plan's cost of coverage.

*Optimized Payment Arrangements*

Health Savings Accounts (HSAs)

Health Reimbursement Accounts (HRAs)

Cadillac Tax

The IRS has indicated in recent guidance that employer contributions to HSAs and employee and employer contributions to HRAs will count as plan value for purposes of the ACA's high value excise ("Cadillac") tax.

After tax employee contributions to HSAs will not be counted toward the value of the plan even though the employee contribution can be deducted from the employee's income tax at year end. Given this guidance, HDHP plan optimization will likely focus on incenting employee HSA contributions.

*Optimized Payment Arrangements*

Wisconsin health care payment innovator The Alliance has developed an initiative that identified skilled providers for certain services – knee replacements, total hip replacements and coronary artery bypass grafts. The goal is to optimize patient outcomes by:

- Disclosing total industry payments for the procedure
- Ordering imaging using evidence-based guidelines
- Assigning a patient experience manager to each case
- Offering a post-procedure 90 day warranty
- Covering the medical procedures at 100%

More information is located at [www.the-alliance.org/qualitypath/](http://www.the-alliance.org/qualitypath/)

*IRS Reporting Requirements*

Effective January 1, 2015, applicable large employers (ALEs) must file an IRS information return describing the employer's offers of health insurance coverage to its full-time employees.

ALEs must also provide statements to their full-time employees that describe the employer's offer (or non-offer) of health insurance coverage.



*IRS Reporting Requirements*

The employer return (Form 1094-C) will include a certification as to whether the employer offered to its full-time employees the opportunity to enroll in minimum essential coverage under an employer-sponsored plan.

The employee statement (Form 1095-C) must be distributed to the employee and filed with the IRS whether the employee enrolled or waived coverage. Form 1095-C states whether the employee received an offer of coverage for each month of the year along with the type of coverage offered.

*IRS Reporting Requirements*

The employer return (Form 1094-C) must be filed by February 29, 2016, in hard copy or electronically by March 31, 2016.

The employee notice (Form 1095-C) must be distributed to employees by January 31, 2016.

Reporting will be especially complicated for 2015 because transition relief must be reported as well as applicable measurement periods for new hire and on-going variable hour employees.

Julie Lewis  
Nowlan & Mouat, LLP  
100 South Main Street  
Janesville, Wisconsin 53547-8100  
(608) 755-8100  
jlewis@nowlan.com

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## **THE AFFORDABLE CARE ACT'S EFFECT ON EMPLOYEE BENEFIT PLANS – 2015**

presented by Julie A. Lewis  
Nowlan & Mouat LLP  
100 South Main Street  
Janesville, Wisconsin 53547-8100  
(068) 755-8100

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President Obama signed the Affordable Care Act (ACA), *Pub.L. 111-148, 124 Stat. 119 - 1025*, into law on March 23, 2010, and plans began signing new members on October 1, 2013, for Healthcare.gov and state marketplace coverage effective January 1, 2014. Beginning January 1, 2015, the employer mandate became effective for applicable large employers. As of January 1, 2016, all employers will file returns with the Internal Revenue Service reporting on the status of their 2015 group health insurance coverage.

In passing the ACA, Congress selected employer-sponsored group health insurance as the vehicle and model for paying medical costs of the uninsured. The law changed the benefit landscape by mandating certain essential health benefits that were previously optional, requiring coverage for pre-existing conditions and restricting insurers' ability to community rate premiums. In this changed landscape, how do we offer and pay for affordable medical care? Employers, benefits advisors and insurers are looking to the ACA and its regulations for options that will allow them to offer the most complete range of medical benefits supported by tax and insurance-optimized payment options.

This paper reviews the IRS's 2014 and 2015 regulatory guidance regarding customized coverage, optimized payment arrangements and 2015 IRS reporting requirements. A side note on Wisconsin innovator *The Alliance*, an employer health care cooperative, is also included. These developments realign existing and new payment incentives with creative thinking to address targeted medical needs.

### **I. Customized Coverage with Excepted Benefits**

#### **A. Background**

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) added health insurance portability and nondiscrimination provisions to the Public Health Service Act (PHS Act), part 7 of ERISA and chapter 100 of the Internal Revenue Code. Other health care laws, including the Mental Health Parity and Addiction Equity Act of 2008, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, GINA, the Children's Health Insurance Program Reauthorization Act of 2009 and Michelle's Law, piecemealed consumer protection reforms, culminating in passage of the ACA. The ACA organizes mandatory health

care insurance around the principle of guaranteed basic coverage for specified medical conditions within legally enforceable cost limits.

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code exclude certain benefits from ACA requirements. According to 80 F.R. 13995 (03/18/2015), these “excepted benefits” generally fall within four categories of coverage that supplements or adds to the ACA-required minimums:

- *Benefits that are not health coverage but may provide payment for health coverage* – this category of benefits includes auto insurance, liability insurance, workers compensation and accidental death and dismemberment policies. Benefits that belong in this category are always excepted from ACA requirements. See, [62 FR 16894](#), 16903 (Apr. 8, 1997).
- *Limited excepted benefits* – this category of benefits includes limited scope vision and dental benefits and benefits for long-term care, nursing home care, home health care, community-based care and certain health flexible spending arrangements (health FSAs). To be excepted from the ACA, benefits in this category must be either (1) provided under a separate policy, certificate or insurance contract; or (2) otherwise not be an integral part of an insured or self-insured group health plan. See, [79 FR 59131](#) (Oct. 1, 2014).
- *“Noncoordinated excepted benefits”* – this category of benefits includes coverage for a specific disease or illness (e.g., “cancer-only” policies) and hospital indemnity or other fixed indemnity coverage. These benefits are excepted if (1) the benefit is provided under a separate policy, certificate or insurance contract; (2) there is no coordination between the excepted benefit and any benefit exclusion in a group health plan maintained by the same sponsor; (3) benefits are paid without regard to redundancy of (primary) coverage under the same sponsor’s group health plan. See, Q7 in Affordable Care Act Implementation FAQs Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html> and [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs11.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html).
- *Supplemental excepted benefits* – this category of benefits includes supplemental Medicare, veterans/TRICARE or similar supplemental/gap coverage offered under a separate policy, certificate or contract of insurance. [26 CFR 54.9831-1\(c\)\(5\)](#); [29 CFR 2590.732\(c\)\(5\)](#); [45 CFR 146.145\(b\)\(5\)](#); see also EBSA Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>).

Among other things, the federal government is interested in avoiding misuse of the excepted benefit concept that would enable an issuer or employer to provide ACA-excepted group health insurance coverage under a hodgepodge of benefit offerings.

## B. Excepted Benefits in Practice

1. *Voluntary benefits* – Many employers are customizing an internal benefits “marketplace” to include employer-sponsored vision, dental, long-term care, nursing home care and home-health care plans that are offered at a group rate, similar to employer-sponsored life insurance. Employees can choose whether to add these benefits to their individual benefit programs. Dental and vision plans that used to be issued as an integrated part of the

employer's group health plan have, in many cases, been spun off into stand-alone plans that do not have to meet the ACA's prohibition on annual and lifetime benefit maximums. These plans are also being segregated to reduce the plan value for purposes of the Cadillac tax.

2. *Health FSAs* – FSAs have traditionally been considered an excepted benefit that is exempt from ERISA and Code requirements for group health plans. The FSA rules have been tightened to require health care FSAs to meet specific criteria and be part of a Section 125 plan before they will be considered an excepted benefit. See, [http://www.irs.gov/publications/p969/ar02.html#en\\_US\\_2014\\_publink1000204174](http://www.irs.gov/publications/p969/ar02.html#en_US_2014_publink1000204174).

Requirements include (1) the participant's salary reduction amount plus any employer contribution cannot exceed the greater of two times the salary reduction amount or the salary reduction amount plus \$500. A health FSA that does not meet this requirement could fail as an ACA-excepted benefit. This means the plan would be required to comply with ACA mandates including offering essential health benefits and the prohibition on annual benefit limits. Offering a health FSA that is not excepted from or compliant with the ACA could trigger the ACA's \$100 per day excise tax.

3. *Limited Wraparound Coverage* – Employers can offer limited wraparound coverage to employees who are not entitled to ACA-regulated coverage, *e.g.*, part-time employees and retirees. The limited wraparound coverage covers benefits that would not be covered under the individual's health insurance. These benefits might include expanded coverage beyond EHB for in-network medical clinics or providers, the cost of prescription drugs not covered by the individual's primary health plan, home health care coverage or access to an employer's on site clinic at no cost. The annual cost of coverage per employee and covered dependents would be limited to the maximum health FSA annual contribution (\$2,550 in 2015) or 15% of the primary plan's cost of coverage. See, <http://www.gpo.gov/fdsys/pkg/FR-2015-03-18/pdf/2015-06066.pdf>.

## II. Optimized Payment Arrangements

Account-based health plans are high deductible plans connected to a tax-favored payment account – typically a Health Savings Account (HSA) or a Health Reimbursement Account (HRA). To minimize the value of a group health plan for the ACA's high value excise ("Cadillac") tax in 2018, employee contributions to a Health Savings Account can be deducted from the total plan value. See, <http://www.irs.gov/pub/irs-drop/n-15-16.pdf>. Section 4980I(a) imposes a 40% excise tax on the excess benefit provided to an employee in a group health plan. The excess benefit is the excess or amount of the employee's coverage that exceeds a given annual dollar limit – in 2018, \$10,200 for self-only coverage and \$27,500 for other than self-only coverage.

Specific regulations have not been issued yet but Notice 2015-16 says, "Treasury and IRS anticipate that future proposed regulations will provide that (1) employer contributions to HSAs and Archer MSAs, including salary reduction contributions to HSAs, are included in applicable coverage, and (2) employee after-tax contributions to HSAs and Archer MSAs are excluded from applicable coverage." *Id.* Employee after-tax contributions are deductible by the employee but

not excludible from tax by the employer. Yet, the employee contributions will, apparently, be excluded from the excess benefit for Cadillac tax purposes.

Health Reimbursement Account employer and employee contributions will not be excludible from the excess benefit. *See*, Notice 2015-16 (“Treasury and IRS anticipate that future guidance will provide that an HRA is applicable coverage under § 4980I”). This transitional determination implies that the recent momentum supporting tax-preferred payment options may diminish as employers attend to minimizing their excess benefit. As long as employee HSA contributions can reduce plan value, one can expect HDHP plan optimization to focus on HSA incentives.

***Side Note*** – Wisconsin innovation includes projects like *QualityPath* from The Alliance:

- The Alliance is a not-for-profit employer-owned cooperative based in Madison that provides a network of doctors, hospitals and health services to its self-funded employer members.
- *QualityPath* is an initiative of The Alliance that identifies skilled providers for certain common services – knee replacements, total hip replacements and coronary artery bypass grafts – with the goal of optimizing patient outcomes.
- Patients are involved in the care decisions and total industry payments are disclosed.
- Imaging is ordered using evidence-based guidelines and project success is measured based on complications, readmissions and other key quality medical criteria.
- Payments are bundled and patient experience managers handle case administration.
- The program offers a 90 day post procedure warranty that covers surgery-related complications.
- The medical procedures are covered at 100%.
- Additional information can be found at <http://www.the-alliance.org/qualitypath/>

### III. Employer Mandate – IRS Reporting Requirements

The ACA added Section 6056 to the Internal Revenue Code which requires applicable large employers to file annual information returns with the IRS regarding the employer’s offers of health insurance coverage during the previous calendar year. ALEs must also provide statements to their full-time employees that describe the employer’s offer (or non-offer) of health insurance coverage. 26 U.S.C. § 6056;

The return (Form 1094-C) is mandatory and will provide the following information:

- the name, date, and employer identification number of the employer,
- a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A (f)(2)),
- if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—
  - the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage,
  - the months during the calendar year for which coverage under the plan was available,
  - the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and
  - the employer share of the total allowed costs of benefits provided under the plan,
- the number of full-time employees for each month during the calendar year,
- the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans.

ALEs must also file a Form 1095-C for each employee who was ACA full-time during any month of 2015. The employee must also receive a copy of this form regardless of whether s/he was offered or enrolled in group health insurance coverage. Form 1095-C states whether the employee received an offer of coverage for each month of the year along with the type of coverage offered.

Employers must file Form 1094-C in hard copy by February 29, 2016, or electronically by March 31, 2016. Forms 1095-C must be distributed to employees by January 31, 2016. *See*, Instructions for Forms 1094C and 1095C <http://www.irs.gov/pub/irs-dft/i109495c--dft.pdf> .

For 2015, the first mandatory reporting year, reporting may be particularly complicated for employers with significant numbers of variable hour employees. New variable hour employees who are in their initial measurement period are not full-time employees for IRS reporting purposes. Similarly, employees who are in a limited non-assessment period are not full-time until their status is defined and their stability period begins. Employers who are measuring new or variable hour employees are well-advised to document their measurement process carefully because IRS exclusion of these employees as variable hour could result in the imposition of a \$3,000 Section 4980H(b) penalty for each excluded employee.