ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

AHCA (v2): What's In Store for Employer Plan Sponsors Under House-Passed Bill

On May 5, 2017, the House of Representatives passed the American Health Care Act (AHCA) which, if enacted, would make significant changes to the health care provisions affecting employers under the Affordable Care Act (ACA). Most of the provisions impacting self-funded plan sponsors in this version of the AHCA are identical to those contained in the prior version the House considered (which the House failed to vote on). Although the AHCA changes have not become law – the Senate has yet to take up the AHCA and will likely make further changes – employers need to know what is in the AHCA in order to evaluate its potential impact if it becomes law (whether significantly revised or not).

This article provides a summary of key provisions of the AHCA of interest to employers of all sizes. *Remember that these provisions have not yet become law and are likely to be significantly revised before final legislation is enacted. Employers should not rely on the AHCA until it becomes law.*

- **Delay (but not repeal) of the so-called Cadillac Tax.** The IRC 4980I tax on high cost health coverage (the "Cadillac Tax") would be retained. However, the Cadillac Tax would be further delayed until 2026. The Cadillac Tax remains as originally in effect. Thus, the AHCA would continue to include HSA contributions from employers (including pre-tax salary reduction contributions from employees) in calculating the Cadillac Tax.
- **Elimination of individual mandate.** The penalty for failure of an individual to have coverage is reduced to zero effective 1/1/16. Thus, the so-called "individual mandate" would cease back to 2016.
- **Elimination of so-called employer "pay or play" taxes under IRC 4980H.** The employer shared responsibility taxes for applicable large employers are eliminated as they are reduced to zero effective 1/1/16. This would allow employers to revise eligibility language to pre-2015 terms (if desired) – with the only limitations being those that arise under 105(h) for self-funded coverage or insurance contract minimum participation rules.

- **ACA premium tax subsidies remain through 2019.** The existing premium tax subsidies, with some modifications, would remain in place through 2019. The modifications include allowing the credit for catastrophic plans and certain qualified health plans purchased off Exchanges. Starting in 2020, a new health coverage tax credit would replace the ACA premiums tax subsidies (see below).

- **No elimination of ACA reporting (at least not right away).** Unfortunately, applicable large employers (ALEs) will be required to continue reporting offers of coverage during the year to 4980H full-time employees as required by IRC 6056 (Part II of the 1095-C) through the 2019 calendar year (the last forms will be furnished/filed in 2020). The 6056 reporting is relevant not only to the employer shared responsibility taxes but also the ACA premium tax subsidies, which continue through 2019. This reporting may be simplified, however, as employers would likely be able to merely look back at the end of the year and identify those who had months with 130 or more hours of service. The complicated "look back measurement" approach is likely no longer required. Since the individual mandate taxes are reduced to zero effective 1/1/16 the reporting required by IRC 6055, which is used to enforce the mandate, should no longer be required. Starting in 2020, there will be streamlined reporting on Form W-2 relating to the new health coverage tax credit (see below).

- **Additional changes of interest:**

    - The Health FSA salary reduction limit (now at $2600 for 2017) would be repealed beginning 2017;

    - The prescription requirement for OTC drugs would be eliminated beginning 2017;

    - Several significant HSA improvements would go into effect in 2018 – including an increased contribution limit, a retroactive effective date for eligible expenses (up to 60 days after the HSA is established), easier spousal "catchup" contributions, and (effective for 2017) reduction of excise tax on non-medical distributions to 10%.

    - The small employer tax credit for a portion of the cost of SHOP coverage paid by the employer would be repealed at the end of 2019.

    - ACA taxes OTHER than the Cadillac Tax would be repealed, including the sector tax on health insurance premiums (effective in 2017), the additional 0.9% Medicare tax for higher income individuals (effective 2023), and the 2.8% tax on net investment income for higher income individuals (effective 2017).

- Medicare Part D (prescription drug) expenses would again be deductible AND eligible for the RDS subsidy beginning in 2017.

Note that even if final legislation repeals some or all of these tax provisions, the effective date of repeal may change and could be pushed back. Thus, employers should not rely on these effective dates until final legislation is enacted and should continue at this point to apply present-law rules.

- **Allowing States to define essential health benefits (EHB):** Starting in 2020, states would have the ability (through a waiver) to define what are considered to be EHBs. While this change is primarily aimed at those plans that are required to offer EHBs (i.e., non-grandfathered individual and fully-insured small group health plans), it would also impact self-funded plans, because the prohibition on annual and lifetime dollar limits applies to EHBs. Self-funded plans may use any permissible definition of EHB for this purpose. For example, many plans currently use the definition that applies in Utah. If this provision is enacted, plan sponsors may want to review the definition of EHB under any State waivers to determine if the sponsor would like to make a change for purposes of applying the prohibition on annual and lifetime limits.

- **New refundable tax credit in place of premium tax subsidy.** Starting in 2020, a new refundable health coverage tax credit would replace the ACA premium subsidy. The new credit would be a specified dollar amount that would increase based on age and would be phased out based on income. The new credit would not be available to individuals that are eligible for government or employer-sponsored health coverage.

This new credit would affect employers in several ways:

- Employers will have to report offers of group health plan coverage to ALL employees on Form W-2 starting in 2020. It is not clear whether a reporting requirement will apply with respect to retirees for whom a W-2 is not otherwise required. This new reporting requirement is intended to replace the current offer of coverage reporting under 6056. Note the W-2 reporting applies regardless of employer size. (The current requirement that employers report the cost of coverage on Forms W-2 is not changed by the bill.)

- The prior version of the bill included a requirement that when an employee applies for an *advance* credit to pay for coverage, the application must include a written statement from the employer that the employee is or is not eligible for employer-provided coverage. Employers would have been required to provide this statement upon the request of the employee. The AHCA as passed by the House does not include this specific rule and, instead, directs the Secretaries of Health and Human Services and Treasury to develop rules for the advance payment of the credit, including rules that provide "robust verification of all information necessary to establish eligibility" for the advance payment. Thus, regulations could impose a similar requirement on employers.

- **Other modifications for individual and fully-insured small group market plans:** A number of other requirements for individual and small group market plans would be relaxed, including: elimination of the metal tiers (bronze, silver, gold, platinum) starting in 2020 and an increase in permitted age-rating from 3:1 to 5:1, with an option for States to obtain a waiver to allow a greater difference (starting in 2018). ;

- **Late enrollment penalty for individual market coverage would replace the individual mandate:** In place of the ACA individual mandate, the AHCA includes other provisions that are designed to encourage individuals to avoid gaps in health coverage or wait until they are sick to obtain coverage. Starting in 2019, individuals enrolling in individual market coverage who have a gap in coverage of at least 63 days during a 12-month period would be charged an additional 30% surcharge on the premium by the insurer. This surcharge would apply for 12 months. This provision would also apply for individuals with a coverage gap who seek to enroll in individual market coverage during a special enrollment period in 2018.

  In place of the 30% surcharge, States may obtain a waiver that will allow insurers to charge premiums in the individual market based on the health status of the individual (e.g., based on whether the individual has a pre-existing health condition). Like the 30% surcharge, this individual pricing based on health status would apply to individuals who have a gap in coverage and would apply for 12 months. Insurers could not deny or limit coverage for pre-existing conditions, but could charge individuals more based on a pre-existing condition. A State may only obtain a waiver to allow rating based on health status if the State has a qualifying high risk program in place.

As we go to press, the AHCA is still being debated and the Senate has yet to take action on the AHCA. Once again, all eyes should be on Congress for the next several weeks. ■