Employee Benefits Report

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IRS, HHS Cracking Down on "Skinny Plans"

Proposed regulations would close a loophole that allowed certain employers to skirt the Affordable Care Act's minimum value requirement.

Background

The Affordable Care Act applies to employers with 50 or more full-time equivalent employees. It requires them to offer their full-time employees coverage that:

- **Is affordable.** The employee's share of the annual premium for the lowest priced self-only plan can be no greater than 9.5 percent of annual household income.

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This Just In…

Some employers have tried to avoid the Affordable Care Act's (ACA) employer mandate by reducing full-time employees' hours. But doing so can earn you a visit with a judge.

The ACA requires employers with more than 50 full-time equivalent employees to provide affordable health insurance that meets certain minimum coverage requirements. Employers must provide this coverage to all full-time or full-time equivalent employees, which the law defines as working an average of 30 or more hours per week.

What's wrong with reducing employees' hours to avoid covering them? Section 510 of ERISA, the Employee Retirement Income Security Act of 1974, makes it unlawful to "discriminate against a partici-

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- **Meets minimum value standards.** The law defines a minimum value plan as one designed to pay at least 60 percent of the total cost of medical services for a standard population.
- **Covers certain "essential health benefits,"** or ten broad areas of treatments and services. The Affordable Care Act requires all health plans offered in the individual and small group markets, both inside and outside of the health insurance exchanges, to cover essential health benefits. It also prohibits plans from placing annual dollar limits on these essential health benefits for plan years starting January 1, 2014.

The essential health benefits provision—arguably the most costly portion of the law—does not apply to large group health plans. This creates a loophole for large employers, generally those with 101 or more employees. Although large group plans must cover preventive care services with no copayment, they do not have to cover "essential health benefits."

Skinny Health Plans

Skinny plans designed to meet ACA requirements for large employers cover the ACA-required preventive services. To keep premiums low, however, they do not cover the "essential health benefits," or place a very low limit on those benefits, such as $100 per hospitalization. This allows insurers to develop skinny plans that cost only a fraction of what an ACA-compliant plan would cost.

Although skinny plans meet the ACA's affordability standard—because they don't cover much—they do not meet the minimum value standard. A health plan meets this standard if it's designed to pay at least 60 percent of the total cost of medical services for a standard population.

The ACA makes a premium tax credit available to individuals who do not receive qualifying employer health coverage, if their household income is between 100 percent and 400 percent of the federal poverty level. This allows them to buy coverage on the individual market. People who receive an offer of ACA-qualifying coverage from their employer cannot get the tax credit. If the ACA applies to your organization and any of your employees or their family members enroll in an individual market health plan through an exchange and receive a tax credit, you will be subject to a fine.

In early November 2014, the IRS warned that "certain group health plan benefit designs that do not provide coverage for inpatient hospitalization services are being promoted to employers." In a notice issued by the IRS, the agency said that it believed that such plans "…do not provide the minimum value intended by the minimum value requirement." The IRS said that it and the Department of Health and Human Services (HHS) would propose regulations to close this loophole, with the goal of finalizing and implementing them in 2015.

For a review of your organization's health plan or to discuss your coverage options for 2015 renewals, please contact us.

pant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan…[or to interfere] with the attainment of any right to which such participant may become entitled under the plan…." If an employee or government agency brought suit against an employer, a judge could interpret cutting an employee's hours to avoid providing health insurance benefits as a violation of Section 510.

Penalties for violating Section 510 include back pay and reinstatement of benefits plus attorney's fees.

COBRA Basics

COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, allows qualifying people formerly covered by an employer's group plan and their dependents to temporarily continue health coverage at group rates. Employers who don't understand their COBRA obligations can face penalties.

Certain employer-sponsored health plans must offer COBRA continuation coverage to employees who undergo a "qualifying event" that causes them to lose group health coverage.

Which employers must comply with COBRA? An employer must offer COBRA continuing coverage if it had 20 or more employees in the prior year and offers a group health plan. Please note that COBRA will apply to some employers that do not have to comply with the Affordable Care Act because they have fewer than 50 employees. As long as you have 20 or more employees and offer group coverage, COBRA applies. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time. If you employe a lot of part-time employees but have fewer than 20 employees on your health plan, COBRA rules still apply to your plan.

Which employees are eligible for COBRA continuation benefits? An employee must have had coverage under the group health plan on the day before a "qualifying event" occurs. "Qualifying events" include:

- Termination of employment, unless it is for gross misconduct, or a reduction in hours worked (e.g., from full-time to part-time) that causes loss of benefits.
- An employee's death, divorce, legal separation or eligibility for Medicare.
- A change in status of a covered dependent or spouse. Under the Affordable Care Act, children can remain on a parent's plan until age 26. This applies regardless of whether they are a student, dependent or even married.
- Being called up for active military duty.

Types of coverage. Employers must offer COBRA beneficiaries the same coverage and coverage choices (such as during open enrollment periods) as they do to non-COBRA beneficiaries. Any benefit changes for active employees will also apply to COBRA beneficiaries.

Length of coverage. COBRA provides for up to 18 months' coverage for qualifying events such as job termination or a reduced work schedule. Certain qualifying events, or a second qualifying event during the initial coverage period, may extend coverage

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to a maximum of 36 months. Cobra coverage begins on the date that benefits would otherwise have been lost because of a qualifying event. An employer may terminate coverage if a beneficiary does not pay premiums on time, or if the employer stops offering any group health plan.

Notification and election. In the case of divorce, legal separation or a dependent's change of status, such as turning 26, a qualified beneficiary has 60 days to notify the plan administrator. The administrator then has two weeks to notify the person entitled to COBRA benefits, who must decide within 60 days whether to elect coverage. Keep in mind that though an employee may choose coverage on behalf of all other qualified beneficiaries, each beneficiary has the right to independently elect COBRA coverage. For example, if an employee has a family member with an illness at the time he is terminated, that person alone can elect coverage, should he choose.

Cost of coverage. In most cases, the beneficiary pays the full cost of the insurance premiums. In fact, employers may charge up to 102 percent of the premium and keep the extra two percent to cover administrative costs. COBRA beneficiaries must make the initial premium payment within 45 days after the election date, and employers can terminate COBRA coverage if payments are late.

Special rules apply to reservists called up for military service. If military service is for 30 or fewer days, military members and their dependents can continue their coverage at the same cost they were paying before their short service. If military service is longer, the employer can require reservist and dependents to pay as much as 102 percent of the full premium for coverage. However, the military's health plan should cover a family in this situation.

State law. Most states have laws concerning the continuation of benefits. Some cover all employers, including small employers, so your organization might be subject to a state law even if your company is exempt under the federal COBRA law. To find out more about your state's laws regarding continuation of coverage, contact your health insurance broker or an employment law professional. Be sure to inquire about the types of benefit plans covered, eligibility rules, what constitutes a qualifying event, notification requirements, length of coverage and how coverage may be terminated.

In our next issue, we'll cover COBRA audits and how they can save you money. If you'd like more information on administering your COBRA obligations in the meantime, please contact us ■

How to Be a Better Benefits Buyer

Employers spend thousands per employee on health insurance plans. Yet few check the quality of their plan before buying.

When you want to buy a car or appliance or hire a contractor, you can check Consumer Reports and Angie's List for quality ratings. Few would argue that using rating services such as these can save consumers money and aggravation. Yet many employers don't take advantage of rating services available when they buy their employee group health plan.

A recently released survey of employers that offer employee health insurance found that most don't use any objective quality information or ratings in their decision-making process. That's like buying a car because it's cute or you like its color, and hoping for the best.

Anne Weiss, who leads efforts to increase health care value at the Robert Wood Johnson Foundation, said the poll "highlights the fact that there is still a lot of work to be done to educate employers on how to get the most bang for their buck." The survey, conducted by the Associated Press NORC Center for Public Affairs Research, was funded by the Robert Wood Johnson Foundation.

Sixty percent of employers offering health insurance said quality ratings were an important factor when choosing a plan. Despite this, most employers (89 percent) did not use or know about objective health insurance quality information and ratings available. Only 7 percent used objective quality information when buying employee health coverage.

That's not to say that most employers are making blind decisions—many rely on other sources. Health plans provide

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quality information; 36 percent of employers offering health insurance use this. Another 15 percent of employers use brokers or consultants to evaluate health insurance plan quality. These sources might provide useful information, but are they as unbiased as other sources? To get a true picture of a health plan's quality, you might want to consult unbiased sources.

Where Can You Find Plan Rating Information?

The Associated Press-NORC survey gauged familiarity with four different sources of quality information: HEDIS scores, NCQA, eValue8™, and CAHPS data. An overview of each follows.

HEDIS Scores: Healthcare Effectiveness Data and Information Set scores. The National Committee for Quality Assurance (NCQA) collects these health insurance plan quality ratings. NCQA looks at three measures to develop its ratings: clinical quality, consumer satisfaction and NCQA's review of a health plan's health quality processes. If your plan isn't listed, that might not necessarily reflect on its quality or lack thereof. NCQA only ranks health plans that publicly report their quality information.

The NCQA also issues a State of Health Care Quality Report every year. Instead of focusing on individual plans, the report takes a look at the key quality issues the U.S. health system faces and progress toward providing evidence-based medicine. You can obtain a copy at no charge at http://store.ncqa.org/index.php/2014-state-of-health-care-quality-report.html

eValue8™ Data: The National Business Coalition on Health (NBCH) represents regional coalitions of more than 4,000 mid- and large-sized employers that provide health insurance coverage to approximately 35 million employees and their dependents. This nonprofit provides research and other resources to improve the employer-sponsored health system. According to the NBCH, "eValue8™ asks health plans probing questions about how they manage critical processes that control costs, reduce and eliminate waste, ensure patient safety, close gaps in care and improve health and health care." NBCH develops eValue8™ ratings using information on how plans handle health promotion, disease management, provider payments, and provider quality measurements.

CAHPS: The U.S. Agency for Healthcare Research and Quality (AHRQ) conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. CAHPS asks consumers and patients to report on and evaluate their experiences with healthcare providers. These surveys focus on aspects of quality that consumers are best qualified to assess, such as providers' communication skills and ease of access to health services.

All CAHPS surveys are in the public domain, which means that anyone can download and use these surveys to assess consumer experiences. Individuals and organizations use the survey results to inform their decisions and to improve the quality of healthcare services. For more information on CAHPS health plan surveys, see https://cahps.ahrq.gov/surveys-guidance/hp/index.html

Please keep in mind that if you can't find objective quality information on your health plan, that doesn't mean it's not a good plan. Rating organizations might not rate plans from smaller or regional insurers. If you're interested in learning more about health plan quality, please contact us. We can help you interpret and evaluate materials available for your health plan.

No Reimbursements for Individual Coverage

The U.S. Departments of Labor, Health and Human Services and Treasury issued guidance that draws a bright line delineating employer group health coverage from individual coverage sold to those who aren't covered by government or employer-sponsored health plans.

Under the guidance issued November 6, employers cannot reimburse employees to cover individual policy premiums. "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," the guidance states.

Nor may employers set up health reimbursement account (HRAs) that enable employees to purchase coverage and access advance premium tax credits for individual plans sold in the state health benefit exchange marketplace. HRAs are group health plans and therefore employees participating in them are ineligible for the credits or cost-sharing reductions, the departments reason. "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," the guidance notes.

In addition, the guidance states employers may not offer cash to an employee in poor health in order to steer the employee away from a large employer's group health plan. Such arrangements violate Health Insurance Portability and Accountability Act (HIPAA) provisions barring discrimination based on one or more health factors, the departments conclude. "Offering, only to employees with a high claims risk, a choice between enrollment in the standard group health plan or cash, constitutes such discrimination."

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