September 16, 2014

Five ACA Issues That Employers Should Be Following

Employers have about three months to finalize their employer mandate compliance plans under the Affordable Care Act ("ACA"). While most employers are in the final stages of planning, this month's *Take 5* will address five ACA issues that employers should be aware of as they move forward into 2015 and beyond, including:

For the latest news and insights concerning the Affordable Care Act, please visit and subscribe to Epstein Becker Green's blogs www.healthemploymentandlabor.com and www.healthlawadvisor.com.

1. **ACA-related litigation**
2. **Employer mandate reporting**
3. **Section 510 liability**
4. **Alternatives to traditional plan offerings**
5. **The looming Cadillac tax**

---

1. The ACA May Have Its Day in Court … Again

In late July 2014, the U.S. Court of Appeals for the District of Columbia and the U.S. Court of Appeals for the Fourth Circuit issued conflicting opinions on a key aspect of the ACA. In *Halbig v. Burwell*, D.C. Cir., No. 14-508, and *King v. Burwell*, 4th Cir., No. 14-1158, the courts were asked to determine whether the Internal Revenue Service ("IRS") has the authority to administer subsidies in federally facilitated exchanges when the statute itself specifically authorizes subsides only in state-run exchanges.

The heart of the dispute centers on the text of the ACA itself. According to the ACA, penalties under the employer mandate are triggered only if an employee receives a subsidy to purchase coverage "through an Exchange established by the State under section 1311" of the ACA. If a state elected not to establish an exchange or was unable to establish an operational exchange by January 1, 2014, the Secretary of

Health and Human Services was required to establish a federally facilitated exchange under section 1321 of the ACA. Thus, subsidies provided through federally facilitated exchanges would originate from an exchange established under section 1321 of the ACA, not through an exchange established by the state under section 1311.

In 2012, the IRS promulgated regulations making subsidies available in both federally facilitated exchanges and state-run exchanges. In those regulations, the IRS asserted that "the statutory language … and other provisions" of the ACA "support the interpretation" that credits are available to taxpayers who obtain coverage through both state and federally facilitated exchanges.

The plaintiffs in both cases argued that the IRS does not have the authority to administer subsidies in states that did not establish a state-run exchange because the exchanges were not "established by the State." In *Halbig*, the D.C. Circuit agreed with the appellants and vacated the IRS regulation. The court focused heavily on the plain meaning of the statutory text and concluded that "the ACA unambiguously restricts the ... subsidy to insurance purchased on Exchanges established by the state." In an opinion issued only hours later, the Fourth Circuit, in *King*, agreed with the IRS that the statutory language was not plain, but ambiguous. Accordingly, the court upheld the subsidies "as a permissive exercise of the agency's discretion."

On September 4, the D.C. Circuit agreed to vacate the original decision and rehear the case *en banc*. Oral argument will be heard in December. If the full D.C. Circuit reverses the *Halbig* decision, then the existing "circuit split" would be resolved. However, given the fact that only four justices are required to grant *certiorari*, it is possible that this line of cases could reach the Supreme Court even if the full D.C. Circuit overturns the *Halbig* decision. Of particular note, in *National Federation of Independent Business v. Sebelius,* 132 S. Ct. 2566 (2012), four justices voted to overturn the individual mandate. If those same four justices voted to grant *certiorari*, this line of cases would be heard.

If the plaintiffs in these cases ultimately prevail, the impact on employers would be significant. Employer mandate penalties are triggered only if an employee receives a subsidy to purchase coverage through an exchange. Accordingly, if subsidies are unavailable, then no penalties could be triggered against an employer in the 36 states with federally facilitated exchanges. While overturning the IRS decision could have a profound impact on employer responsibilities under the mandate, litigation is highly unpredictable and employers should continue with their mandate plans until the courts rule definitively.

2. Planning for Employer Mandate Reporting Can Begin

In late August 2014, the IRS released draft forms and instructions relating to the reporting requirements under sections 6055 and 6056 of the Internal Revenue Code. Now that employers have these draft forms and instructions, as well as the final

regulations released earlier this year, steps to ensure compliance can begin in earnest. Section 6055 requires employers that sponsor self-insured plans, as well as other entities that provide minimum essential coverage, to file annual returns reporting information for each individual for whom the entity provides coverage. Section 6055 reporting is needed to determine compliance with the individual mandate and will also help determine individuals' eligibility for premium tax credits because of a lack of minimum essential coverage.

Section 6056 requires large employers that are subject to the employer mandate (i.e., employers with 50 or more full-time employees or equivalents) to file reports on the coverage that they offer to their full-time employees and furnish related statements to employees. Section 6056 reporting is needed to determine compliance with the employer mandate and will also help identify individuals who are ineligible for premium tax credits because they received an offer of coverage from their employers.

As a reminder, employers are not required to file these forms for 2014 (though the IRS encourages employers to voluntarily report). Reporting will be required for 2015, however, with first returns due in early 2016. The section 6056 reporting, in particular, will help determine compliance with the employer mandate (and whether any associated penalties will be imposed). Therefore, employers should begin planning for the filing of these forms as soon as feasible.

3. How to Minimize Section 510 Liability

In general, the employer mandate requires that employers offer coverage to any employee who works, on average, 30 hours or more each week. For many employers, especially those who employ high numbers of part-time workers, the employer mandate will drastically increase the number of employees eligible for coverage. In response, some employers have sought to control employer mandate costs by limiting the number of hours employees work to less than 30. While this response seems logical and well within the employer prerogative to manage its workforce, it nevertheless could expose employers to class action liability.

ERISA section 510 is the anti-abuse provision of ERISA and was enacted to prevent unscrupulous employers from discharging or interfering with their employees' rights to benefits. For example, section 510 was intended to stop the practice of discharging employees shortly before their pension rights vested. In the wake of the ACA, however, plaintiffs' attorneys will likely use section 510 as an avenue for suing employers that have reduced hours to limit exposure to employer mandate liability.

Given the language of section 510, plaintiffs are likely to argue that an employer's act of limiting or capping hours interfered with an employee's rights to benefits under the plan. The most likely ERISA section 510 claim involves capping or cutting the hours of an employee who had previously averaged over 30 hours a week, although

arguments can certainly be made in response to any employer action limiting the hours of employees.

A critical element in ERISA section 510 cases is whether the employer acted with a specific intent to interfere with an employee's rights to benefits under a plan. Because plaintiffs must prove intent, there are steps that employers can take to minimize ERISA section 510 exposure along these lines. Perhaps most importantly, employers should avoid making public statements on their employer mandate strategy to the press or workforce. These statements will not only alert plaintiffs' attorneys of a potential target, but also can be used as evidence of intent in a lawsuit.

Employers should centralize their communications around employer mandate issues so that the organization has a single consistent message. This message should be communicated to all levels of management to ensure that conflicting statements are not released. These messages should focus on the staffing needs of the business and should not be political or mention any strategy to avoid the costs associated with the employer mandate.

Finally, employers that are planning on reducing employee hours should do so in a way that limits their exposure to ERISA section 510 claims. Because employees who previously worked 30 hours per week are the most likely plaintiffs, employers may consider grandfathering such employees. Additionally, moving forward, employers should ensure that their employment agreements are modified to notify employees who are not benefits-eligible of their status.

4. If It Sounds Too Good to Be True, Then It Probably Is

As discussed above, the employer mandate will, in some cases, dramatically increase the number of employees eligible for employer-sponsored coverage, which will, in turn, increase costs to the employer. The cost of providing coverage to these additional employees has led some employers to look for alternatives to their traditional plan offerings. While there are certainly legitimate ways to lower costs, there is an increasing number of plan designs and schemes that could expose employers to liability, including (1) employer payment plans, (2) drug importation programs, (3) incentive schemes, and (4) classification schemes.

First, an employer payment plan is one in which an employer does not offer its own group health plan but, rather, reimburses employees for the premiums they pay to purchase their own plan on the open market. Under ERISA, however, because these plans provide medical benefits, they are considered group health plans and subject to the ACA's market reform provisions. The IRS has been concerned for some time that employers are using employer payment plans and other similar structures to sidestep their ACA obligations. Consequently, the IRS published Notice 2013-54 as well as answers to FAQs, which state that "such an arrangement fails to satisfy the market reforms and may be subject to a $100/day excise tax per applicable

employee (which is $36,500 per year, per employee) under section 4980D of the Internal Revenue Code."

Second, drug importation programs are another area of interest for employers. Recently, a number of off-shore pharmacies have begun marketing foreign mail-order drugs to employers as a way to cut costs. There are a number of variations of these programs, but they all involve the direct shipment of foreign prescriptions to employees. Because foreign drugs are unlikely to have received Food and Drug Administration ("FDA") approval, their importation is unlawful under the federal Food, Drug, and Cosmetic Act. Until recently, the FDA has exercised its discretion not to enforce the importation prohibitions aggressively. That non-enforcement strategy, however, has begun to change, and the FDA has recently investigated several carriers that ship these drugs into the United States. Additionally, FDA guidance exists in the group health plan context that warns employers that, if the FDA were to take action, it would likely target the plans and not the individual members.

Third, employers need to be wary of incentive schemes—programs marketed to employers that seek to offer full-time employees an incentive to decline the opportunity to enroll in coverage. The incentives vary by program, but there is typically some monetary remuneration for employees who drop coverage. Under the employer mandate, employers are required to offer their full-time employees an "effective opportunity to elect to enroll (or decline to enroll)" in coverage. It is unlikely that employees who are provided an incentive to decline coverage will have had an effective opportunity to enroll in the employer's plan.

Lastly, classification schemes could subject employers to unforeseen employer mandate liability. A classification scheme is any one of a number of schemes marketed to employers that attempts to classify their full-time employees as either independent contractors or leased employees from another organization. Although the employer mandate only applies to full-time employees and not independent contractors or leased employees, it relies upon the long-established IRS test for determining whether an employment relationship exists, and not mere titles. Thus, false constructs that label employees as contractors will not shield the employer from employer mandate liability.

5. The Cadillac Tax Is Barreling Down the Road

Beginning in 2018, employer-sponsored group health plans will be subject to a 40 percent non-deductible excise tax on the dollar amount of coverage that exceeds certain specified thresholds. While these thresholds are indexed to increase over time for inflation, the 2018 threshold for individual coverage is $10,200 and the threshold for family coverage is $27,500. (These thresholds will be adjusted upwards for early retirees and individuals in high-risk professions. In 2018, the thresholds for early retirees and high-risk professions will be increased $1,650 for individual coverage and $3,450 for family coverage.)

The Cadillac tax applies to "applicable employer-sponsored coverage." Applicable employer-sponsored coverage includes coverage under any group health plan made available to the employee by an employer, which is excludable from the employee's gross income or would be excludable if it were employer-provided coverage. Thus, major medical coverage and coverage provided under account-based plans (e.g., flexible spending accounts and health savings accounts) are likely includable in the calculations. The ACA specifically excludes stand-alone vision and dental plans. Until regulations are released, however, it is unclear whether wellness programs or other affinity programs will be affected.

The Cadillac tax applies to the dollar amount that exceeds the specified threshold. According to the ACA, the excess amount for a given month is determined using the following formula:

- "The aggregate cost of the applicable employer sponsored coverage of the employee for the month, over
- An amount equal to 1/12 of the annual limitation for the calendar year in which the month occurs."

For example, if an employer is offered individual coverage that costs $12,000 per employee, the excess amount for a month would be calculated as follows: ($12,000 / 12 months) − ($10,200 / 12) = $150. Therefore, the employer would be taxed 40 percent of $150, or $60 per employee per month. Over a year, the Cadillac tax liability per employee would be $720.

The ACA states that each "coverage provider" is responsible for payment of the tax. In the context of insured group health plans, the coverage provider is the health insurance issuer. For self-insured plans, the entity that administers the plan is the covered provider responsible for payment of the tax. Most self-insured plans use a third-party administrator ("TPA") to administer benefits and be responsible for paying the tax. In the case of multiemployer plans, the plan's insurer would be responsible for paying the tax. While the penalties may technically apply to the health insurance issuer or TPA, it is likely that the cost of the penalties will be passed down to the employer.

Although the Cadillac tax was designed to apply to high-end health plans that provide the most generous level of benefits to employees, it is likely that the Cadillac tax will affect far more modest plans and could be a significant burden on most employers. Thus, employers must take action now to restructure their health coverage offerings to avoid the tax. In addition to changing benefit design, many employers have implemented population health management techniques, such as wellness programs, telehealth operations, and direct contracting with providers to improve the health of their population, which will, in turn, lower their costs. Finally, unionized employers need to address the Cadillac tax in their upcoming rounds of bargaining in order to ensure that the contractual changes necessary to avoid the tax are in place before 2018.

****

This issue of *Take 5* was written by **David W. Garland**, **Adam C. Solander**, and **Brandon C. Ge**. For additional information about the issues discussed above, please contact the Epstein Becker Green attorney who regularly handles your legal matters or one of the authors of this *Take 5*:

David W. Garland	**Adam C. Solander**	**Brandon C. Ge**
New York	Washington, DC	Washington, DC
212/351-4708	202/861-1884	202/861-1841
dgarland@ebglaw.com	asolander@ebglaw.com	bge@ebglaw.com

About Epstein Becker Green

Epstein Becker & Green, P.C., established in 1973, is a national law firm with approximately 250 lawyers practicing in 10 offices, in Baltimore, Boston, Chicago, Houston, Los Angeles, New York, Newark, San Francisco, Stamford, and Washington, D.C. The firm's areas of practice include health care and life sciences; employment, labor, and workforce management; and litigation and business disputes. Founded as an industry-focused firm, Epstein Becker Green has decades of experience serving clients in health care, financial services, retail, hospitality, and technology, among other industries, representing entities from startups to Fortune 100 companies. For more information, visit www.ebglaw.com.

Your Workplace. Our Business. ®