Health Reform Rollercoaster

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When POTUS signed the most recent executive order related to health care reform, it was only a small incremental step to direct the agencies to loosen some rules on health reform that will eventually impact the coverage available on the marketplaces and permit some to use what had been short term, interim or bridging policies. This will impact who will remain in the groups purchasing health insurance on the marketplaces. This order also attempted to encourage agencies to broaden who can participate in association health plans and to encourage the expansion of health reimbursement accounts.

The more significant action came later in the same day when the Attorney General of the U.S. sent a memo to the Administrator of the Center for Medicare and Medicaid Services ordering that the cost sharing reduction payments to insurers offering coverage on the marketplaces created by the Affordable Care Act (the "ACA") stop immediately. This reversed the administration's prior position of waiting for the litigation pending in the D.C. Circuit regarding the legality of how the legislation providing such cost sharing reduction payments (or cost sharing subsidies) was enacted to continue to completion through the appellate process. Stopping payment of the cost sharing subsidies to the insurance carriers will likely have a far quicker impact on premiums for individual coverage purchased on the marketplaces. Some insurers responded by quickly raising rates on insurance policies sold to individuals on the marketplaces to reflect the loss of the subsidies. *As the price of individual policies available on the marketplace increases, individuals are more likely to look for coverage from their employer's plans which may not look as expensive when the subsidies that helped to reduce the individual policy costs are gone.*

EO – What It Really Does

The federal agencies are charged with administering the federal laws as they were passed by Congress and signed into law. An EO cannot unilaterally change the laws enacted by Congress. The founders chose separation of powers in designing our government to have the different branches have different authorities to counterbalance each other- part of the checks and balances.

The EO wanted the agencies to facilitate association health plans and expand the parties who can participate in these plans. This is not likely to increase any access to coverage for individuals, but may impact coverage available to small businesses. This also did not provide any relief from the ACA mandated benefits or other requirements that increase the cost of coverage. This will not happen quickly, the EO only directed the Secretary of Labor to consider proposing regulations to do this within 60 days. The regulatory process takes time as it is established by federal laws which the agencies must follow.

The EO's Recommendation of HRAs and a Recent Decision Worth Considering

The EO also encouraged the expansion of health reimbursement arrangements for the payment of health insurance premiums to larger employers. The EO directed the Department of Labor, IRS and Health and Human Services Department to consider guidance to expand health reimbursement arrangements ("HRA") to expand HRA availability. Last year the Qualified Small Employer Health Reimbursement Arrangements were added to the Code for employers with fewer than 50 full-time employees with statutory exceptions from the Affordable Care Act's benefit mandates on group health plans. Unfortunately, the EO is not able to remove those benefit mandates. Should the tri-agency group find a way to expand HRAs to larger employers considering the ACA requirements, this will only be one potential hurdle to consider. Earlier this year, the U.S. Supreme Court permitted the 9th Circuit's decision in *Flores v. City of San Gabriel* to stand which dealt with opt-out payments under a flexible benefit plan and reminds us that the Fair Labor Standards Act ("FLSA") requirements must be considered in structuring benefits. *Flores* was clear that the status of a plan under the Code or under ERISA does not mean that it is also a bona fide benefit plan under the Fair Labor Standards Act. If it is not a bona fide benefit plan under the FLSA and it is not otherwise covered by an exclusion from the regular rate of pay calculation under the FLSA, the benefit may need to be considered in the calculation of overtime for non-exempt employees. The law is a tangled interwoven web…*So expanding HRA utilization will require employers to*

analyze the arrangement not only under the Code, ERISA, and the ACA, but also considering the potential interaction of the FLSA.

Since these are directives to start a regulatory process on the above items (other than the removal of the cost sharing reduction payments which was immediately effective), this is the beginning of a road that will take some time. Recently agencies have seen courts return regulations for additional justification of the positions taken in the regulation when the regulation was challenged in federal court. (The D. C. District Court remanded the EEOC's regulation on wellness programs for justification of the 30% cap on incentives and there are motions pending on clarifying just what that means to the regulation currently). Once the court decides how its order impacts the application of the EEOC's wellness regulations, a follow up alert will be sent. The remands for further justification of regulations will likely slow the process so that the agencies can address more fully any issue raised in the preambles to the regulations. As a result, we are not likely to see major changes in any regulations coming quickly.

Legislative Proposals

Around this time Congress started on a new Bi-Partisan bill on certain aspects of the ACA. The Murray-Alexander Individual Market Stabilization Bill is purported to stabilize the individual insurance markets and insurer exits from the marketplace. This bill restores the cost sharing reduction payments that the memo from the Attorney General discussed above ordered to cease. These are restored for 2017, 2018 and 2019, so it is not a permanent fix. It relaxes and accelerates the processing of the state waiver program which permits states to apply to provide innovative value-based insurance designs for dealing with coverage for low income persons, persons with serious health conditions and other vulnerable populations. It also proposes to expand the availability of the catastrophic coverage plans to people above the age of 30, while providing protection to those with serious medical conditions. It does not purport to change the coverage mandates in the ACA for employer sponsored plans. So while it is proposing to make changes to the ACA, it is not making changes that impact large employer group health plans. It is not clear if this bill has any chance of passing both houses of Congress or being signed into law as the sands are always shifting in Washington DC.

The Bottom Line

The ACA coverage and benefit mandates are still the law for employer sponsored group health plans, as are the reporting mandates and the employer shared responsibility tax for employers with 50 or more full-time employees (as defined by the ACA). So employers subject to such tax should move forward on preparing the new 2017 Forms 1095-C. The 2017 Form 1095-Cs are substantially the same as the 2016 forms, but with the transitional rule codes eliminated.

Employers need to be aware that there may be more employees seeking coverage during annual enrollment due to the loss of the cost sharing reduction subsidies on the marketplaces driving up individual insurance costs.

Employers and their advisors need to remember that our employee benefit plans while valid under the ERISA and the Code may not be "bona fide benefit plans" under the FLSA unless designed to also meet those requirements and it is always good to have a good labor and employment lawyer on speed dial.

As for any legislation, we still need to sit back, wait and watch.

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