Note to Congress: You need to clearly and consistently define MEC NOW!!!!!!

By Bill Colopoulos

One of the ACA's cornerstone promises was that the new law would guarantee all Americans access to substantive, affordable healthcare. The ACA would fulfill this promise by establishing universal standards for healthcare benefits and funding.

So far, the ACA has failed to provide substantive benefits to many Americans simply because the new law inadequately defines what is or is not "Minimum Essential Coverage" i.e., specifically what kinds of healthcare services must be covered under a health benefit program.

This lack of clarity regarding what must be covered under a plan providing minimum essential coverage has troubling implications for both individuals and sponsors of health benefit program. Plans in compliance with the ACA can be structured to be low-cost tax dodges for their employers – and in some cases – a way for the Federal Government to avoid providing adequate funding for uninsured and underinsured Americans.

Defining Minimum Essential Coverage

What is Minimum Essential Coverage? The ACA's definition of minimum essential coverage fails to address what exactly it means by the terms "minimum", "essential" or "coverage". Instead, the law defines which plans are MEC – without defining what is meant by MEC.

Here is an example: a google inquiry of MEC. Our search reveals not a description of what coverage must be provided by a MEC plan, but rather tells us what kinds of plans qualify as MEC:

- Any health plan bought through the Health Insurance Marketplace
- Individual health plans bought outside the Health Insurance Marketplace, if they meet the standards for qualified health plans
- Any "grandfathered" individual insurance plan in force since March 23, 2010 or earlier
- Any job-based plan, including retiree plans and COBRA coverage (our $1 VEBA scenario fits in here)
- Medicare Part A or Part C (but Part B coverage by itself doesn't qualify)
- Most Medicaid coverage, except for limited coverage plans
- The Children's Health Insurance Program (CHIP)
- Coverage under a parent's plan
- Most student health plans (check with your school to see if the plan counts as minimum essential coverage)
- Health coverage for Peace Corps volunteers
- Certain types of veterans health coverage through the Department of Veterans Affairs
- Most TRICARE plans
- Department of Defense Non-appropriated Fund Health Benefits Program
- Refugee Medical Assistance
- State high-risk pools for plan or policy years that started on or before December 31, 2014

Thus, the ACA identifies ***who*** is MEC (by plan type) but not ***what*** MEC is from a benefit perspective. And since "health plans" are listed as MEC "who", any program defined by the IRC as a health plan – including a stand-alone HRA/VEBA or FSA with an outstanding balance (being defined by an old tax code as a health plan) – can be considered to be an MEC plan. That is how the IRS can lead us to the ridiculous result of a former employee's VEBA account with a $1 outstanding balance (for example) being MEC. Unfortunately, while no one would argue that a $1 VEBA plan provides adequate healthcare for the accountholder, no one can dispute the tax code interpretations of the ACA rules that designate the $1 VEBA account as being MEC. As the rules stand now, such an account is clearly is MEC since MEC is defined as a "health plan" – and a VEBA account balance of $1 is technically likewise a "health plan".

The ACA's benefit rules make vague references to coverage themes; presumably for the purpose of establishing general benefit standards that must apply to all forms of healthcare insurance. But the focus there seems to be centered again on another theme other than benefit coverage: funding vehicles: i.e., insured plans as opposed to self-insured programs.

Core benefits provisions

ACA's benefit overage themes are reflected in the law as core benefit provisions; e.g., prohibitions on annual or lifetime maximums, disallowance of pre-existing conditions limitations and provide an almost compulsive guarantee of prevention and wellness benefits; mandating that preventive services be "covered at 100%; not subject to deductibles or other cost sharing benefit features" in any health plan. But since no definitions are provided regarding what kinds of healthcare services (other than preventive) must be provided by a MEC plan, there is no stipulation that a MEC plan must provide substantive healthcare benefits in other areas, such as hospital, outpatient, lab, prescription drugs, etc. There are also no defined coverage requirements in terms of how much an MEC plan must pay; apparently – even for preventive and wellness benefits.

Even more confusing, the ACA rules regarding its core benefit provisions are apparently able to be swept aside by other provisions and other parts of the IRC. Again, going back to our $1 VEBA health plan, apparently, the annual and lifetime maximum prohibition doesn't override the basic IRC designation of the VEBA as a "health plan" and, ergo, a minimum essential coverage program. At best, this is a contradiction in the ACA rules, at worst, a deliberate parsing of the rules and tax codes interpreted for the express purpose of limiting the government's liability to provide premium tax credits.

The lack of a specific MEC coverage definition has created many debates over what needs to be included in the aforementioned kinds of plans in order for them to be considered MEC. Here again, the law is unclear and inordinately complex.

To be or not to be – MEC? Fully Insured or Self-Insured

In some cases, the definition of what is MEC is health plan-specific: it relies upon which entity and type of health plan provides MEC; most often linked to the question of how the plan is funded. For example, for an insured plan or a plan offered through one of the health exchanges to be considered MEC, the health plan must provide a list of "qualified" health benefits composed from a list of "essential health benefits" which must include comprehensive coverages in each of the following categories of health care services:

1. Outpatient care (e.g., physician expenses)
2. Emergency room

3. Treatment in the hospital for inpatient care
4. Care before and after childbirth
5. Mental health and substance use disorder services: This includes behavioral health treatment, counseling, and psychotherapy
6. Prescription drugs
7. Rehabilitative services. This includes physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more.
8. Lab tests
9. Preventive services including counseling, screenings, and vaccines to preserve health and care for managing a chronic disease.
10. Pediatric services: This includes dental care and vision care for children

Moreover, in order to qualify as MEC, so-called "qualified" (fully insured) health plans must also provide substantive coverage amounts in each mandated category of expense i.e., the percentage of expenses incurred by the insured in each of the above categories that will be paid by the plans must reach certain payment thresholds for the plan to pass the MEC test.

The mandated expense coverage levels applicable to qualified health plans are defined with "metal" plan designations for their expense coverage value: Platinum plans that cover on average 90% or more of the expenses in each of the above categories; Gold 80 – 90%; Silver 70 – 80% and Bronze 60 - 70%. Thus, the definition for exchange-based and insured health plans includes not only a comprehensive list of the kinds of services that must be covered, but also defines a minimum level of expense coverage that the qualified health plan must provide. In the context of insured plans, MEC translates to coverage that is real and substantive. This is clearly reflective of the intent – and promise – of the ACA.

But when we step out of the insured universe into the realm of the self-insured plan, MEC definitions no longer link to essential health benefits and the metal plan designations and expense coverage requirements remarkably disappear. These "other" MEC plans fall into the abyss of unspecified benefit definitions; with no coverage level requirements. Self-insured MEC plans may provide little or no coverage for anyone who is covered by them.

That's because ACA law provides no equivalent definitions of essential health benefits and expense coverage requirements that apply to self-insured MEC programs. Thus, a VEBA balance of $1, being a "health plan" by definition – and in the absence of any regulation requiring coverage type or amount – can constitute MEC under the right set of circumstances. The practicality or adequacy of the coverage is not addressed by ACA rules; either for the employee or their dependents. What is or is not MEC becomes a matter of how tax codes created for the ACA intersect and combine with pre-ACA tax codes.

And the IRS is actively exploiting special interpretations of the tax code that uses the vagueness of MEC definitions to serve another purpose: protect the Federal Treasury from premium tax credit liabilities to anyone who may be covered under any sort of MEC plan – even the account holder of that $1 VEBA "health plan" mentioned earlier.

The all-too-possible nightmare scenario

Let's take a closer look at the practical consequence of the particularly absurd interpretation of an outstanding VEBA account balance equating to MEC:

In our example, John Doe worked for ABC Company and was covered under ABC's self-insured health plan until 2005. When John left ABC Company's employment, he had an outstanding balance in a VEBA account of $150. Being generally healthy, a year or two passed and John forgot about his VEBA account. From 2005 - 2011, John worked for two other companies and changed his resident address three times; finally moving to a new state in 2011; essentially losing all contact with his former employer, ABC Company.

In 2014, John was laid off from his most recent job, applied for coverage under his new state's health insurance exchange and applied for premium tax credits for him and his family. When filing out the application for his premium tax credits; John answered the question "do you have MEC" "no"; having either forgotten about his old VEBA balance or not identifying it as a health plan; based on the simple (and quite logical) assumption that an account valued at $150 wouldn't go very far to providing adequate healthcare for himself and his family.

The IRS would have no way of knowing about the existence of John's old VEBA account leftover from his days with ABC Company, so John's application for premium tax credits was approved in 2014 and he began his exchange family coverage; receiving an annual PTC subsidy valued at just over $18,000 for himself and his family's "Silver" health insurance plan.

Fast forward to 2-1-2016: John's old company ABC, looking through its VEBA account files finds that John's VEBA is still showing an unused balance of $150. Dutifully, per ACA reporting rules, ABC Company files a 1095-B form with the IRS stipulating that John still has an old VEBA with an outstanding balance of $150 and has had this "plan" since 2005! But since ABC Company has lost touch with John and could not find his new address, they could not send him his copy of the 1095 form. Therefore, when ABC Company files the form with the IRS, John is unaware of the filing.

In early November, 2016, John is surprised with a notice from the IRS stating that because he had MEC at the time of his exchange coverage application back in 2014, he misrepresented the information on his PTC application; thus voiding his application. Therefore, he must now refund two years and 10 months' worth of premium tax credits that he was, in retrospect, not qualified to receive – a total of $51,000!!!

So where has the IRS and Congress gone wrong with John? Clearly neither intended that John's old VEBA account balance would equate to being adequate health insurance coverage for John and his family; preventing him from obtaining premium tax credits needed to pay for adequate health insurance. Surely the IRS and Congress would not claim that John's $150 VEBA balance comprises a practical health insurance option for his family. Or would it?

As the law is written now, the IRS could seek a full premium tax credit refund from John; presumably, plus penalties. How would John come up with the money? And what would he do for health insurance for himself and his family while unemployed? It is unlikely that either issue would be favorably resolved if the strict tenets of existing tax codes were followed.

Do we parse the provisional IRC rules OR adjudicate the intent of the ACA?

Believe it or not, the IRS works at the direction of Congressional authority. Thus, the intent of the ACA's rules should trump the parsing of IRS rules interpretations – at least in theory. But in order for Congress to be able to instruct the IRS to fix the mess it has created by not clearly or adequately defining MEC, it must revise the language of the ACA.

The easy fix would be to clarify the MEC definition by making MEC synonymous with Essential Health Benefits; regardless of plan type or funding mechanism. In other words, eliminate the distinction between coverage requirements for insured and self-insured plans and consolidate the definition of MEC to that of what is a Bronze qualified health plan under the current definition of essential health benefits. That would mean that a minimum value plan (a Bronze level plan) would now define what is MEC; much in the same way as minimum value plans must be offered now by applicable large employers in order to avoid penalty exposure under IRC 4980H (b).

This simple rules revision would accomplish several goals:

1. It would clarify what is and what is not MEC in practical terms; providing real and substantive benefits to all MEC health benefit recipients; regardless of what kind of plan they happened to be enrolled.
2. It would achieve benefit equity between self-insured and fully-insured health plans
3. It would greatly simplify the reporting process; avoiding the need for issuance of 1095-B forms for terminated employees with outstanding HRA/VEBA balances.

Lastly, and perhaps most importantly, this simple change would reflect the true intention of the architects of the ACA which clearly meant to promote universal health care by offering everyone access to real and substantive health benefit coverage.

To do any less creates nearly endless opportunities for employers and (apparently) the federal government to "game" the system when it comes to what benefits are provided and to whom under a nearly endless variety of benefit coverage scenarios. To do any less would also preserve the likelihood of absurd interpretations of ACA coverage rules surfacing that would continue to contradict the true intention of the law.

Bill Colopoulos is a healthcare economist. He is president and founder of Next Generation Healthcare Economics. You can follow Bill's Blog on this and other healthcare economics topics or contact Bill directly at bc@nexgenhce.com