FAQs about Affordable Care Act Implementation (Part XXII)

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November 6, 2014

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at http://www.dol.gov/ebsa/healthreform/ and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Compliance of Premium Reimbursement Arrangements

On September 13, 2013, DOL and the Treasury published guidance on the application of the market reforms and other provisions of the Affordable Care Act to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements.(1) HHS issued contemporaneous guidance to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in the DOL and Treasury Department guidance.(2) Subsequently, on May 13, 2014, two FAQs were made available on the IRS website addressing employer health care arrangements.(3)

The Departments' prior guidance explains that employer health care arrangements, such as HRAs and employer payment plans, are group health plans that typically consist of a promise by an employer(4) to reimburse medical expenses up to a certain amount. The Departments' guidance clarifies that such arrangements are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual limits under Public Health Service Act (PHS Act) section 2711 and the requirement to provide certain preventive services without cost sharing under PHS Act section 2713.(5) The Departments' guidance further clarifies that such employer health care arrangements will not violate these market reform provisions when integrated with a group health plan that complies with such provisions. However, an employer health care arrangement cannot be integrated with individual market policies to satisfy the market reforms. Consequently, such an arrangement may be subject to penalties, including excise taxes under section 4980D of the Internal Revenue Code (Code).

Q1: My employer offers employees cash to reimburse the purchase of an individual market policy. Does this arrangement comply with the market reforms?

No. 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. Therefore, the arrangement is group health plan coverage within the meaning of Code section 9832(a), Employee Retirement Income Security Act (ERISA) section 733(a) and PHS Act section 2791(a), and is subject to the market reform provisions of the Affordable Care Act applicable to group health plans. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate PHS Act sections 2711 and 2713, among other provisions, which can trigger penalties such as excise taxes under section 4980D of the Code. Under the Departments' prior published guidance, the cash arrangement fails to comply with the market reforms because the cash payment cannot be integrated with an individual market policy.(6)

Q2: My employer offers employees with high claims risk a choice between enrollment in its standard group health plan or cash. Does this comply with the market reforms?

No. PHS Act section 2705,(7) which was incorporated by reference into ERISA section 715 and Code section 9815, as well as the nondiscrimination provisions of ERISA section 702 and Code section 9802 originally added by the Health Insurance Portability and Accountability Act (HIPAA), prohibit discrimination based on one or more health factors. Offering, only to employees with a high claims risk, a choice between enrollment in the standard group health plan or cash, constitutes such discrimination. While the Departments' regulations implementing this provision(8) permit more favorable rules for eligibility or reduced premiums or contributions based on an adverse health factor (sometimes referred to as benign discrimination), in the Departments' view, cash-or-coverage arrangements offered only to employees with a high claims risk are not permissible benign discrimination. Accordingly, such arrangements will violate the nondiscrimination provisions, regardless of whether (1) the cash payment is treated by the employer as pre-tax or post-tax to the employee, (2) the employer is involved in the selection or purchase of any individual market product, or (3) the employee obtains any individual health insurance.

Such offers fail to qualify as benign discrimination for two reasons. First, if an employer offers a choice of additional cash or enrollment in the employer's plan to a high-claims-risk employee, the opt-out offer does not reduce the amount charged to the employee with the adverse health factor. Rather, the employer's offer of cash to a high-claims-risk employee who opts out of the employer's plan effectively increases the premium or contribution the employer's plan requires the employee to pay for coverage under the plan because, unlike other similarly situated individuals, the high-claims-risk employee must accept the cost of forgoing the cash in order to elect plan coverage. For example, if the employer's group health plan requires all employees to pay $2,500 toward the cost of employee-only coverage under the plan, but the employer offers a high-claims-risk employee $10,000 in additional compensation if the employee declines the coverage, for purposes of discrimination analysis, the effective required contribution by that high-claims-risk employee for plan coverage is $12,500 – that is, the $2,500 required employee contribution for employee-only coverage under the employer's plan plus the $10,000 of additional compensation that the employee would forgo by enrolling in the plan. Because a high-claims-risk employee must effectively contribute more to participate in the group health plan, the arrangement violates the rule that a group health plan may not on the basis of a health factor require any individual (as a condition of enrollment) to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan.

Second, the Departments' regulations generally permit providing, based on an adverse health factor, enhancements to eligibility for coverage under the plan itself but not cash as an alternative to the plan. In particular, the regulations permit providing plan eligibility criteria that offer extended coverage within the plan and subsidization of the cost of coverage within the plan based on an adverse health factor.(9) An example in the Departments' regulations illustrates that a plan may have an eligibility provision that provides coverage to disabled dependent children beyond the age at which non-disabled dependent children become ineligible for coverage.(10) Another example in the regulations illustrates that a plan may provide coverage free of charge to disabled employees, while other employees pay a participant contribution towards coverage.(11) However, in the Departments' view, providing cash as an alternative to health coverage for

individuals with adverse health factors is an eligibility rule that discourages participation in the group health plan. This type of arrangement differentiates based on a health factor and is outside the scope of the Departments' regulations on benign discrimination, which permit only discrimination that helps individuals with adverse health factors to participate in the health coverage being offered to other plan participants. The Departments intend to initiate rulemaking in the near future to clarify the scope of the benign discrimination provisions.

Finally, because the choice between taxable cash and a tax-favored qualified benefit (the election of coverage under the group health plan) is required to be a Code section 125 cafeteria plan, imposing an effective additional cost to elect coverage under the group health plan could, depending on the facts and circumstances, also result in discrimination in favor of highly compensated individuals in violation of the Code section 125 cafeteria plan nondiscrimination rules.

Q3: A vendor markets a product to employers claiming that employers can cancel their group policies, set up a Code section 105 reimbursement plan that works with health insurance brokers or agents to help employees select individual insurance policies, and allow eligible employees to access the premium tax credits for Marketplace coverage. Is this permissible?

No. The Departments have been informed that some vendors are marketing such products. However, these arrangements are problematic for several reasons. First, the arrangements described in this Q3 are themselves group health plans and, therefore, employees participating in such arrangements are ineligible for premium tax credits (or cost-sharing reductions) for Marketplace coverage. 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. DOL guidance indicates that the existence of a group health plan is based on many facts and circumstances, including the employer's involvement in the overall scheme and the absence of an unfettered right by the employee to receive the employer contributions in cash.[(12)]

Second, as explained in DOL Technical Release 2013-03, IRS Notice 2013-54, and the two IRS FAQs addressing employer health care arrangements referenced earlier, such arrangements are subject to the market reform provisions of the Affordable Care Act, including the PHS Act section 2711 prohibition on annual limits and the PHS Act 2713 requirement to provide certain preventive services without cost sharing. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate PHS Act sections 2711 and 2713, among other provisions, which can trigger penalties such as excise taxes under section 4980D of the Code.

Footnotes

1. See DOL Technical Release 2013-03, available at http://www.dol.gov/ebsa/newsroom/tr13-03.html, and IRS Notice 2013-54, available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf.
2. See Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf.
3. Available at: www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements.
4. These arrangements may be sponsored by an employer, an employee organization, or both. For simplicity, this section of the FAQs refers to employers. However, this guidance is equally applicable to HRAs sponsored by employee organizations, or jointly by employers and employee organizations.
5. Section 1001 of the Affordable Care Act added new PHS Act §§ 2711-2719. Section 1563 of the Affordable Care Act (as amended by Affordable Care Act § 10107(b)) added Code § 9815(a) and ERISA § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.
6. See DOL Technical Release 2013-03, available at http://www.dol.gov/ebsa/newsroom/tr13-03.html, and IRS Notice 2013-54, available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf. See also Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf.
7. Prior to the enactment of the Affordable Care Act, Titles I and IV of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, added section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act (HIPAA nondiscrimination and wellness provisions). Affordable Care Act section 1201 also moved those provisions in the PHS Act from section 2702 to section 2705.
8. 26 CFR 54.9802-1 (g); 29 CFR 2590.702(g);146.121(g).
9. 26 CFR 54.9802-1 (g)(1)(i); 29 CFR 2590.702(g)(1)(i);146.121(g)(1)(i).
10. 26 CFR 54.9802-1 (g)(1)(ii), Example 1; 29 CFR 2590.702(g)(1)(ii), Example 1;146.121(g)(1)(ii), Example 1.
11. 26 CFR 54.9802-1 (g)(2)(ii), Example; 29 CFR 2590.702(g)(2)(ii), Example;146.121(g)(2)(ii), Example.
12. See 29 CFR 2510.3-1(j).