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Intricacies of Health Premium Reimbursements

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Intricacies of Health Premium Reimbursements

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Background

Before the enactment of the Affordable Care Act ("ACA"), it was not uncommon for employers, smaller employers in particular, to provide cash amounts that employees could apply to the purchase of health insurance in the individual market. These practices did not, at least at first, have any formal name or designation. Later, in or about 2002, the IRS coined the term "health reimbursement arrangement" (or "HRA") to loosely describe the practice, which was generally considered uncontroversial. The reimbursement of properly substantiated individual market health care premiums was expressly sanctioned by a 1961 IRS revenue ruling, Rev. Rul. 61-146, 1961-2 C.B. 25.

With the ACA's enactment, benefits brokers and consultants, among other vendors, saw an opportunity to encourage the use of employment-based health premium reimbursement arrangements as a potential source of revenue. (Promoters of these arrangements typically charge a per-member-per-month administration fee.) Some of the claims made on behalf of these post-ACA arrangements were unfounded, e.g., that employees could use pre-tax employer funds to access individual market products offered through public exchanges. This claim is nonsense, of course. Individual products offered through public exchanges or marketplaces must be paid for with after-tax dollars (Internal Revenue Code § 125(f)(3)).

The ACA included a series of insurance market reforms, the purpose of which is to broaden the risk pool, i.e., to distribute health care risks across healthy and non-healthy populations alike. The law also limits practices in the voluntary insurance markets—e.g., medical underwriting, pre-existing exclusions, risk-based rating, renewal practices, and segmented risk pools—that might or are expected to lead to adverse selection. (Adverse selection occurs when a purchaser of health insurance understands his or her own potential health risk better than health insurance insurers do, and health insurance issuers are therefore less able to accurately price their products.)

The ACA's insurance market reforms that take the form of amendments to the Public Health Service Act that are also incorporated by reference into the Internal Revenue Code (the "Code") and the Employee Retirement Income Security Act ("ERISA"). As a consequence, the ACA insurance market reforms generally apply to health insurance issuers and all manner of group health plans, whether maintained by private sector employers, churches, or units of government. A general description of the nearly two-dozen ACA insurance market reforms is beyond the scope of this paper. There are, however, two particular reforms that are important. They are:

- *Public Health Service Act § 2711*, which generally bars group health plans from imposing annual or lifetime limits on the dollar amount of benefits (the "annual dollar limit prohibition"); and

- *Public Health Service Act § 2713*, which requires non-grandfathered group health plans to provide preventive services without imposing any cost-sharing requirements (the "preventative services requirement").

It is these two provisions that call into question the use of employment-based health premium reimbursements arrangements. To understand why requires a brief digression.

The ACA's insurance market reforms apply to "group health plans" among other entities. ACA § 1301(b)(3) provides that the term group health plan "has the meaning given such term by section 2791(a) of the Public Health Service Act." Public Health Service Act § 2791(a) provides as follows:

> 1. DEFINITION. — The term ''group health plan'' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
>
> 2. MEDICAL CARE. — The term "medical care" means amounts paid for —
>
> A. the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
>
> B. amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and
>
> C. amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

ERISA Section 3(1) defines the term "employee welfare benefit plan" broadly to mean:

> "[A]ny plan, fund, or program … established or [ ] maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, … medical, surgical, or hospital care or benefits, or benefits in the event of sickness …."

Thus, an HRA is *itself* a group health plan, since it qualifies as a welfare plan, and it "provides medical care . . . to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise." But is an HRA separately subject to the ACA's insurance market reforms? That is, under what circumstances can an HRA be paired with other coverage for compliance testing purposes (an "integrated" HRA), and under what circumstances is pairing not allowed (a "stand-alone" HRA)? An integrated HRA does not violate the prohibition against annual limits on essential health benefits so long as the coverage offered with the integrated HRA/group health plan complies with the ACA. These questions were first raised in a June 28, 2010 interim final regulation implementing the annual dollar limit prohibition (75 Fed. Reg. 37188 (Jun. 28, 2010)). While this regulation provided that a stand-

alone HRA would not satisfy the annual dollar limit prohibition, it did not explain exactly which arrangements were (or were not) stand-alone.

The question of the extent to which an HRA might be integrated with other coverage was further complicated by the circumstance that the annual dollar limit prohibition (as set out in Public Health Service Act § 2711) does not apply to health Flexible Spending Accounts ("FSAs") within the meaning of Code § 106(c)(2). (Without this statutory exception, health FSAs would no longer exist.) This omission led some promoters to conclude that stand-alone HRAs could claim the benefit of this exception, since HRAs were health FSAs.

January 24, 2013 FAQ

On January 24, 2013, in a set of Frequently Asked Questions the Department of Labor and the Treasury Department/IRS clarified their stance on integrated and stand-alone HRAs, saying:

> "[A]n HRA is not integrated with primary health coverage offered by an employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage provided by the employer and meeting [the annual dollar limit prohibition]."

Despite its apparent clarity, the January 24, 2013 FAQ did not appear to have any effect on promoters of stand-alone HRAs.

Notice 2013-54

On September 13, 2013, the Departments of the Treasury/IRS, Labor and Health and Human Services (the "Departments") issued coordinated guidance on a handful of items relating to ACA implementation, including:

1. Application of the ACA's insurance market reforms to health reimbursement arrangements (HRAs) and certain other health care arrangements;

2. Application of the ACA's insurance market reforms to certain health FSAs; and

3. Treatment of employee assistance programs, or "EAPs," as excepted benefits.

(The Treasury/IRS version appeared in Notice 2013-54, 2013-40 I.R.B. 287.) The guidance generally applies for all plan years beginning on and after January 1, 2014, but it could be applied for earlier periods. With respect to HRAs and medical FSAs, the guidance addressed the annual dollar limit prohibition and the preventative services requirement. For purposes of regulating HRAs and medical FSAs the Departments introduce and define a new term, "employer payment plan," to mean and include a group health plan:

> "under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy such as … arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee …."

An example of an employer payment plan is an arrangement under which an employer reimburses an employee's substantiated premiums for non-employer sponsored medical insurance. Curiously, an employer payment plan does not include "an employer-sponsored arrangement under which an employee may choose either *cash or an after-tax amount* to be applied toward health coverage." (Emphasis added). This statement was later qualified. The effect of the guidance is to make it impossible for any employer payment plan other than a plan that provides only excepted benefits (discussed below) to provide for the purchase of health coverage in the individual market.

Notice 2013-54 covers the following topics.

HRAs integrated with a group health plan

An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses incurred by the employee or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. Reimbursements are excludable from the employee's income. Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years. HRAs are often used in conjunction with fully-insured group health plans to help employees cover uninsured out-of-pocked costs (e.g., co-pays, deductibles, coinsurance and other cost sharing). When used in this fashion, they are sometimes referred to colloquially as "medical expense reimbursement plans" or "MERPs."

HRAs are not, however, limited to the payment of unreimbursed medical expenses. HRA amounts can also be applied to pay health insurance premiums. It is this aspect of HRAs that has been seized upon by proponents of "consumer-driven health care" (or "CDHC") to enable a defined contribution model for employer-based health insurance. Under one CDHC approach, the employer provides a sum of money, which employees may apply to the purchase of health insurance coverage in the individual market without restriction and without any further employer involvement. The guidance unequivocally bans the use of HRAs to enable CDHC arrangements of this sort. According to the Departments, these arrangements run afoul of both the annual dollar limit prohibition and the preventative services requirement.

The Notice establishes two, alternative rules on what it means for an HRA to be "integrated." One applies where the HRA is paired with a plan that fails to provide minimum value; the other where the plan does provide minimum value. (Minimum value is a measure of a plan's generosity. Generally, a minimum value plan is one that provides major medical benefits.) Under either method, integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor. For example, an employee of an employer that offers an HRA could apply HRA amounts to the payment of employee premiums under the group health plan of his or her spouse who works for an unrelated employer.

HRA / Non-Minimum Value Plan

An HRA is integrated with a group health plan that fails to provide minimum value if:

1. The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits;

2. The employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage);

3. The HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage;

4. The HRA is limited to reimbursement of one or more of the following: co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute essential health benefits; and

5. Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

The guidance advises that "the opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage . . . and will therefore preclude the individual from claiming" a premium tax credit from a public insurance exchange.

HRA / Minimum Value Plan

An HRA is integrated with a group health plan that provides minimum value if:

1. The employer offers a group health plan to the employee that provides minimum value;

2. The employee receiving the HRA is actually enrolled in a group health plan that provides minimum value, regardless of whether the employer sponsors the plan (non-HRA minimum value group coverage);

3. The HRA is available only to employees who are actually enrolled in non-HRA minimum value group coverage, regardless of whether the employer sponsors the non-HRA minimum value group coverage; and

4. Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

The two integration methods differ in their treatment of coverage of medical care that constitutes essential health benefits. Under the first method described above (i.e., where an HRA is paired with a group health plan that fails to provide minimum value), HRA amounts cannot be expended on essential health benefits. To provide otherwise would effectively place an annual limit on an essential health benefit.

The guidance provides some helpful rules that apply where an employee ceases to be covered under the group health plan that is integrated with the HRA. Unused amounts may be used to reimburse medical expenses in accordance with the terms of the HRA after an employee ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the ACA's market reforms.

Retiree Coverage

The ACA's insurance market reforms do not apply to an HRA that has "fewer than two participants who are current employees on the first day of the plan year" — e.g., a retiree-only HRA. Thus, a stand alone HRA that provides retiree-only coverage is permitted. Such an arrangement constitutes an eligible employer-sponsored plan, which is minimum essential coverage for any month in which funds remain available in the HRA (including amounts retained in the HRA during periods of time after the employer has ceased making contributions). A retiree covered by a stand-alone HRA for any month will not be eligible for a premium tax credit for that month.

Impact on Minimum Value

Notice 2013-54 furnishes rules on the impact of integrated HRA coverage on the determination of minimum value. Generally, amounts newly made available for the current plan year under the HRA may be considered in determining whether the arrangement satisfies either the affordability requirement or the minimum value requirement, but not both.

- Amounts newly made available for the current plan year under the HRA that an employee may use only to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan count only toward the minimum value requirement; and

- Amounts newly made available for the current plan year under the HRA that an employee may use to pay premiums or to pay both premiums and cost-sharing under the primary employer-sponsored plan count only toward the affordability requirement.

These rules apply only where the integrated HRA and the primary group health plan are maintained by the same employer. Amounts newly made available for the current plan year under an HRA count neither toward affordability nor minimum value where primary coverage is offered by another employer.

2013-2014 Transition Rule

Whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, could be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and could not be credited at a faster rate than the rate that applied during 2012.

Health Flexible Spending Arrangements

A health FSA is a benefit designed to reimburse employees for medical care expenses incurred by the employee, or the employee's spouse, and dependents. Contributions to a health FSA do not result in gross income to the employee. While health FSAs are generally funded by salary reduction, employers may provide additional health FSA benefits in excess of the salary reduction amount. For plan years beginning after December 31, 2012, the amount of the salary reduction is limited to $2,500 (indexed).

The ACA's insurance market reforms, including the annual dollar limit prohibition and the preventative services requirement, do not apply to a group health plan that provides only excepted benefits. Excepted benefits include, among other things, accident-only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and certain health FSAs. A health FSA provides *only* excepted benefits if:

- Other (non-excepted benefit) group health plan coverage is made available to employees by the employer; and

- The arrangement is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).

A health FSA that does not qualify as an excepted benefit is generally subject to the ACA's market reforms, including the preventive services requirements. The Departments had previously ruled that a health FSA is not subject to the annual dollar limit prohibition, irrespective of whether the health FSA provides only excepted benefits. Because a health FSA that is not an excepted benefit is not integrated with a group health plan, it will fail to meet the preventive services requirements.

The 2010 interim final rules implementing the annual dollar limit prohibition refer to prior law and guidance under which an HRA was deemed to be a health FSA where:

> "[T]he maximum amount of reimbursement which is reasonably available to a participant under an HRA is not substantially in excess of the value of coverage under the HRA."

While the meaning of the phrases "maximum amount of reimbursement which is reasonably available to a participant" and "the value of coverage under the HRA" are less than clear, some vendors used this rule to claim that their HRA was really a health FSA that was not subject to the ACA's annual dollar limit prohibition or preventative services requirement. The Notice rejects this claim, pointing out the interim final rule "was intended to clarify the rules limiting the payment of long-term care expenses by health FSAs." As a consequence, an HRA cannot be deemed to be a health FSA in order to avoid the application of the ACA's insurance market reforms. This rule is consistent with the common-sense view of what constitutes an HRA since an HRA is paid for solely by the employer and not provided pursuant to salary reduction election.

The Notice also indicates that the annual dollar limit prohibition exemption for health FSAs applies only to a health FSA that is offered through a cafeteria plan. Thus, a health FSA that is not part of a cafeteria plan has no basis to claim that it is not subject to that requirement. The Departments announced that they intend to amend the annual dollar limit prohibition regulations to conform to the position taken in the guidance.

Employee Assistance Plans as Excepted Benefits

The Departments announced their intent to amend the regulations governing excepted benefits to provide that benefits under an EAP are considered to be excepted benefits, but only if the program does not provide "significant benefits in the nature of medical care or treatment." Pending actual rulemaking, the Departments also announced that they will apply this standard.

IRS FAQ on Employer Health Care Arrangements

In a separate set of FAQs issued in June 2014, the IRS addressed the question of whether post-tax contributions made any difference. That is, if the cash stipend paid by the employer was in the form of after-tax compensation that could be applied to the purchase of individual market coverage, would the arrangement be deemed integrated for ACA purposes? The IRS concluded, no, saying:

> Q1. What are the consequences to the employer if the employer does not establish a health insurance plan for its own employees, but reimburses those employees for premiums they pay for health insurance (either through a qualified health plan in the Marketplace or outside the Marketplace)?
>
> Under IRS Notice 2013-54, such arrangements are described as employer payment plans. An employer payment plan, as the term is used in this notice, generally does not include an arrangement under which an employee may have an after-tax amount applied toward health coverage or take that amount in cash compensation. As explained in Notice 2013-54, these employer payment plans are considered to be group health plans subject to the market reforms, including the prohibition on annual limits for essential health benefits and the requirement to provide certain preventive care without cost sharing. Notice 2013-54 clarifies that such arrangements cannot be integrated with individual policies to satisfy the market reforms. Consequently, 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.

Thus, while an after-tax amount is not an employer payment plan, it is a group health plan that is subject to the same rules vis-à-vis ACA compliance. Though not stated, it is implicit in this response is that, when the applicability of the after-tax amount is in no way restricted, i.e., when the employee need not apply it to health insurance, there is no ACA violation. This statement was later clarified in Notice 2015-17, described below.

November 6, 2014 FAQs

On November 6, 2014, the Departments issued a set of FAQs that targeted specific abuses that had come to their attention. These included a clarification that a stand-alone HRA is *itself* a group health plan subject to the ACA insurance market reforms. The Departments also took aim at schemes under which an employer offers employees with high claims risk a choice between enrollment in its standard group health plan or cash, claiming that this amounts to a violation of the bar on taking health status into consideration. Lastly, the FAQs nixed a particularly loopy arrangement under which a vendor markets a product to employers claiming that employers can cancel their group policies; sets up a Code Section 105 reimbursement plan that uses health insurance brokers or agents to help employees select individual insurance policies; and allows eligible employees to access the premium tax credits for Marketplace coverage.

Notice 2015-17

While the policy underlying the ban on stand-alone HRAs seems firmly entrenched, the Departments nonetheless had a practical problem: the practice of advancing cash to enable employees to purchase individual market and other health coverage was previously widespread among small employers. Moreover, promoters of stand-alone HRAs appear to have made a significant dent in that market, despite repeated warnings from the regulators. The IRS responded with Notice 2015-17, 2015-7 I.R.B. __, which provided the following, limited relief.

Small employers

Employers who are not "applicable large employers" (i.e., those with fewer than 50 full-time and full-time equivalent employees) who maintained an employer payment plan are provided an exemption from penalties. The IRS observed that, because the SHOP Marketplace was not yet fully implemented, relief is appropriate. Accordingly, no excise tax will be incurred by a small employer offering an employer payment plan for 2014 or for the first half of 2015 (i.e., until June 30, 2015). These employers are not required to file IRS Form 8928 (regarding failures to satisfy requirements for group health plans under Chapter 100 of the Code, including the market reforms). This relief is limited to stand-alone HRAs that *only* reimburse insurance premiums.

S corporation healthcare arrangements for 2-percent shareholder-employees

Where an S corporation pays for or reimburses premiums for individual health insurance coverage covering a 2-percent shareholder, the payment or reimbursement is included in income but the 2-percent shareholder-employee may deduct the amount of the premiums under Code § 162(l), provided that all other eligibility criteria for deductibility under Code § 162(l) are satisfied. (The notice refers to these arrangements as "2-percent shareholder-employee healthcare arrangements.") The notice advises that the "Departments are contemplating publication of additional guidance on the application of the market reforms to a 2-percent shareholder-employee healthcare arrangement." Until such guidance is issued, however, penalties "will not be asserted for any failure to satisfy the market reforms by a 2-percent shareholder-employee healthcare arrangement." Thus, S corporations that maintain such arrangements are not required

to file IRS Form 8928 solely as a result of having a 2-percent shareholder-employee healthcare arrangement. This relief does not extend to employees of an S corporation who are not 2-percent shareholders. Relief may be available to these latter employees, however, under the rules governing small employers.

Integration of Medicare premium reimbursement arrangement/TRICARE-related HRAs

Generally, the reimbursement of Medicare premiums for active employees or medical expenses for employees covered by TRICARE constitutes an employer payment plan within the meaning of Notice 2013-54. Such an arrangement may not be integrated with Medicare or TRICARE coverage to satisfy the market reforms because neither Medicare coverage nor TRICARE is a group health plan.

Notice 2015-17 provides that an employer payment plan that pays for or reimburses Medicare Part B or Part D premiums is integrated with another group health plan if:

1. The employer offers a group health plan (other than the employer payment plan) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value;

2. The employee participating in the employer payment plan is actually enrolled in Medicare Parts A and B;

3. The employer payment plan is available only to employees who are enrolled in Medicare Part A and Part B or Part D; and

4. The employer payment plan is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums.

The IRS hastens to add that "to the extent such an arrangement is available to active employees, it may be subject to restrictions under other laws such as the Medicare secondary payer provisions."

Similar relief is afforded with respect to arrangements under which an employer reimburses (or pays directly) some or all of medical expenses for employees covered by TRICARE.

Increases in employee compensation to assist with payments of individual market coverage

Notice 2015-17 makes clear what was only implied in an earlier FAQ, i.e., where the applicable of the after-tax amount is in no way restricted, i.e., the employee need not apply it to health insurance, then there is no ACA violation. The IRS explains in this regard that such an arrangement "will not constitute a group health plan [and] is not subject to the market reforms."

Summary

The table set out below summarizes the rules governing employer payment plans.

Employer Payment Plan Type	Subject to annual dollar limit prohibition?	Subject to preventative services requirements?	Regulatory Status
Stand-alone HRA (i.e., reimburses individual market premiums)	Yes	Yes	Fails to satisfy annual dollar limit prohibition and preventative services requirement
Stand-alone retiree HRA	No	No	A stand-alone retiree HRA provides minimum essential coverage (which renders participants ineligible for premium tax credits)
Excepted benefit health FSA	No	No	Not subject to the annual dollar limit prohibition and preventative services requirement, and does not provide minimum essential coverage (participant remains eligible for premium tax credits)
Non-excepted benefit health FSA funded under a Code Section 125 cafeteria plan	No	Yes	Fails to satisfy the preventative services requirement
Non-excepted benefit health FSA not funded under a Code Section 125 cafeteria plan	Not yet determined	Yes	Fails to satisfy the preventative services requirement; may also fail the annual dollar limit prohibition
After-tax employee contributions which participant may (but is not required to) use to purchase individual market coverage	No	No	An arrangement under which after-tax employee contributions may be used to purchase individual market coverage or applied to any other purpose is not an employer payment plan. These amounts are simply additional, after-tax compensation.
Pre-tax or after-tax employee contributions that participant may use to purchase individual market coverage	Yes	Yes	Fails to satisfy annual dollar limit prohibition and preventative services requirement

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