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New FAQs Address Premium Reimbursement Arrangements

Building on previous guidance, the departments have issued three new FAQs that address ACA market reform and other compliance issues for premium reimbursement arrangements. The departments warn that employers could be subject to significant excise taxes if they reimburse employees' individual health insurance premiums either on a pre- or post-tax basis or if they offer employees with high claims risk a choice between the employer's health plan and cash.

Background

Guidance from the Departments of Treasury, Labor, and Health & Human Services (departments) provides that ACA market reforms apply to health reimbursement arrangements (HRAs) and to other arrangements in which an employer contributes towards the cost of an individual health insurance policy either by reimbursing the employee for substantiated premium expenses or directly remitting funds to the insurance company. The departments' position is that these employer payment plans are group health plans subject to the ACA's market reform provisions; they reimburse medical expenses up to a certain amount, and, like HRAs, cannot be integrated with individual marketplace coverage. The arrangements fail to meet the requirements of the market reforms (e.g., prohibition on annual limits and coverage for preventive services) and may be subject to penalties, including excise taxes under section 4980D of the Internal Revenue Code (Code). (See our July 8, 2014 *For Your Information*.)

FAQs Address Premium Reimbursement Arrangements

The departments recently issued FAQs about Affordable Care Act Implementation (Part XXII) that address three scenarios involving an employer that offers a premium reimbursement or similar arrangement to employees for the purchase of individual insurance policies. The guidance reiterates the departments' position that premium reimbursement arrangements are group health plans and unless offered with the employer's group health plan (so that it is integrated with the major medical coverage) will fail to meet ACA market reform requirements. The guidance also provides some important clarifications.

Tax Consequences

One of the themes of these FAQs is that the tax treatment of a premium reimbursement arrangement does not control whether the arrangement will be considered a group health plan. The guidance states that an employer's payment of premiums is part of a plan, fund, or other arrangement established or maintained for purposes of providing medical care to employees, regardless of whether the employer treats the money as pretax or post-tax to the employee. Thus, an employer's promise to reimburse premiums for an individual policy (premiums are considered medical expenses) creates a group health plan defined under the Code, ERISA, and the PHSA that is subject to the ACA's market reforms. These employer healthcare arrangements cannot be integrated with individual market policies to satisfy the market reforms.

> **Comment.** In previous FAQs discussing employer reimbursement of marketplace premiums, the IRS stated that, "[a]n employer payment plan … 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." (See our July 8, 2014 *For Your Information*.) These recent FAQs clarify (and appear to modify the IRS position) that even after-tax amounts designated or otherwise limited to reimburse premiums will be considered a group health plan that will fail to meet market reforms and which could trigger penalties. Presumably, an employer could provide additional (undesignated) salary to employees, which would not be considered a group health plan, even if at some point, the employee chooses to use the money to purchase individual health insurance. Additional clarification from the departments would be welcome.

Choice for High Claims Risk Employees

The FAQs also discuss a scenario in which an employer offers employees with high claims risk a choice between enrollment in the employer's standard group plan or additional cash if they opt out of the employer's plan to purchase an individual policy. The guidance states that this type of program is discriminatory under HIPAA and violates the ACA's market reform provisions. The departments note that although group health plans may engage in "benign discrimination" (i.e., provide more favorable treatment in terms of eligibility, contributions, or benefits to individuals with an adverse health factor), they do not consider arrangements designed to discourage such individuals from enrolling in the plan to be "benign." The departments indicate their intent to provide rules to clarify the scope of the benign discrimination provisions.

> **Comment**. The departments view the cash incentive as an increase in the amount of the premium that an employee must pay to gain coverage under the employer's plan because the employee must forego the cash in order to enroll. This increased premium only affects those employees who are likely to incur higher claims and constitutes impermissible discrimination based on a health factor under HIPAA.

Employer Involvement

The last FAQ focuses on a particular arrangement promoted by several vendors. The vendors claim that employers can cancel their group policies, retain a health insurance broker or agent to help employees elect individual insurance policies, and reimburse some or all of the employees' premiums through a self-funded medical reimbursement plan (referred to in the FAQ as "a section 105 reimbursement plan"). According to the FAQ, vendors assert that under this arrangement employees who would otherwise qualify (e.g., based on income and lack of employer coverage) for premium tax credits to purchase marketplace coverage remain eligible to receive them. The departments clarify that this arrangement is a group health plan subject to the market reforms that cannot be

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integrated with the individual policies and that employees covered by them would not be eligible for premium tax credits.

> **Comment.** The FAQ notes that the creation of a group health plan is based on many facts and circumstances, including employer involvement in the overall scheme and “the absence of an unfettered right by the employee to receive the employer contributions in cash.” The employer’s lack of involvement in picking and purchasing the actual insurance plan for employees is not enough to prevent the arrangement from being a group health plan.

In Closing

Generally, the FAQs reinforce the departments’ continued opposition to employers funding individual health insurance policies. Each of the arrangements described in the FAQs fail to meet the ACA market reforms, which in turn leave the employer open to excise tax penalties. Employers wishing to set up programs that will direct funds to pay for the major medical individual policies of active employees should carefully consider the consequences of such arrangements in light of this guidance. While the option is still open for certain coverages, such as retiree-only, or dental, vision, specified illness, and fixed indemnity (e.g., HIPAA excepted benefits), the door for major medical individual coverage seems shut.

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