Intricacies of Health Premium Reimbursements

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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 pretax 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 nonhealthy 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:

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