United Counties Council of Illinois
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December 5, 2017

To: UCCI Membership

Re: Employee Health Insurance Compensation Programs

***Issue*: Can an employer provide compensation to eligible employees who opt out of the employer's health insurance coverage? If so, can an employer provide this benefit to qualified employees who are also elected officials?**

***Analysis*:**

Employer payment plans fail to comply with the market reforms that apply to group health plans under the Affordable Care Act. An employer payment plan refers to a group health plan wherein the employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy or directly pays a premium for an individual health insurance policy covering an employee.[1] An employer's participation in the above-referenced practice results in an excise tax of $100.00 per day for each employee in which the practice relates.[2]

In the alternative, if an employer increases an employee's salary, but does not condition such compensation on the purchase of health coverage (or otherwise endorse a particular policy, form or issuer of health insurance), then such additional compensation will not be deemed as part of an employer payment plan.[3]

Pursuant to the Internal Revenue Code of 1986 (the "Code"), as amended, individuals serving as public officials are government employees. Section 3401(c) of the Code states that an "officer, employee, or elected official of the United States, a State, or any political subdivision thereof, or the District of Columbia, or any agency or instrumentality thereof", is considered an employee for Federal income tax purposes. Since the U.S. Supreme Court held that the Affordable Care Act is considered a tax, the above-referenced definition of employee would be the prudent definition to determine an elected official's employment status in this matter.[4]

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[1] IRS Notice 2013-54.
[2] Internal Revenue Code, Section 4980D.
[3] IRS Notice 2015-17.
[4] *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

Conclusion:

If an employer provides additional compensation to those employees who opt out of the employer's healthcare coverage for the purpose of paying such funds toward the employee's health insurance policy premium, then such program is a violation of the Affordable Care Act and will be subject to a $100.00 per day excise tax for each employee in which the practice relates.

If an employer provides additional compensation to those employees who opt out of the employer's healthcare program, and such compensation is not conditioned on the employee purchasing alternative health coverage (or otherwise endorse a particular policy, form, or issuer of health insurance), then such program will likely not be considered an employer payment plan.

The above analysis applies to all qualified full-time employees, regardless of whether such employee is an elected official.

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Disclaimer: This opinion was prepared by Giffin, Winning, Cohen and Bodewes, P.C., at the request of UCCI and is to be used solely by UCCI and its members. The State's Attorney is the attorney for the County. Legal advice, if requested, should be sought from the State's Attorney.

Guidance on the Application of Code § 4980D to Certain Types of Health Coverage Reimbursement Arrangements

Notice 2015-17

I. PURPOSE AND OVERVIEW

This notice reiterates the conclusion in previous guidance addressing employer payment plans, including Notice 2013-54, 2013-40 I.R.B. 287,[1] that employer payment plans are group health plans that will fail to comply with the market reforms that apply to group health plans under the Affordable Care Act (ACA).[2] For this purpose, an employer payment plan as described in Notice 2013-54 refers to 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 or directly pays a premium for an individual health insurance policy covering the employee, such as arrangements described in Revenue Ruling 61-146, 1961-2 C.B. 25. This notice also provides transition relief from the assessment of excise tax under Internal Revenue Code (Code) § 4980D for failure to satisfy market reforms in certain circumstances. The transition relief applies to employer healthcare arrangements that constitute (1) employer payment plans, as described in Notice 2013-54, if the plan is sponsored by an employer that is not an Applicable Large Employer (ALE) under Code § 4980H(c)(2) and §§54.4980H-1(a)(4) and -2; (2) S corporation healthcare arrangements for 2-percent shareholder-employees;[3] (3) Medicare premium reimbursement arrangements; and (4) TRICARE-related health reimbursement arrangements (HRAs). This notice also provides additional guidance on the tax treatment of employer payment plans. This notice supplements and clarifies the guidance provided in Notice 2013-54 and other guidance

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[1] There have been four prior issuances on the topics addressed in this notice: (1) FAQs About Affordable Care Act Implementation (Part XI), issued on January 24, 2013 by DOL (http://www.dol.gov/ebsa/faqs/faq-aca11.html) and HHS (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html); (2) IRS Notice 2013-54 and DOL Technical Release 2013-03, issued on September 13, 2013; (3) IRS FAQ on Employer Healthcare Arrangements (http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements); and (4) FAQs About Affordable Care Act Implementation (Part XXII), issued on November 6, 2014 by DOL (http://www.dol.gov/ebsa/faqs/faq-aca22.html) and HHS (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf).

[2] The "Affordable Care Act" or "ACA" refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10). Section 1001 of the ACA added new Public Health Service Act (PHS Act) §§ 2711-2719. Section 1563 of the ACA (as amended by ACA § 10107(b)) added Code § 9815(a) and Employee Retirement Income Security Act (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 §§ 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

[3] For purposes of S corporations, 2-percent shareholder generally means any person who owns more than 2 percent of the stock of the S corporation. See Code §1372(b)(2).

in response to comments and questions from taxpayers and stakeholder groups about certain aspects of that guidance.

The United States Department of Labor (DOL) and the United States Department of Health and Human Services (HHS) (collectively with the Treasury Department and the IRS, the Departments) have reviewed this notice and have advised the Treasury Department and the IRS that they agree with the guidance provided in this notice.

The Treasury Department and the IRS anticipate that clarifications regarding other aspects of employer payment plans and HRAs will be provided in the near future. This notice is intended to provide further clarification of the guidance provided in Notice 2013-54 and other guidance and is intended to be read in conjunction with that guidance.

II. GUIDANCE

Question 1 (Transition Relief for Small Employers from the Code § 4980D Excise Tax): Small employers have in the past often offered their employees health coverage through arrangements that would constitute an employer payment plan as described in Notice 2013-54. If an employer offered coverage through such an arrangement, will the employer owe an excise tax under Code § 4980D?

Answer 1: In general, yes; however, this notice provides limited transition relief for coverage sponsored by an employer that is not an ALE under §§54.4980H-1(a)(4) and -2.

Notice 2013-54 concludes that the arrangements constituting employer payment plans as described in that notice fail to comply with the market reforms and may subject employers to the excise tax under Code § 4980D. At the same time, the Departments understand that some employers that had been offering health coverage through an employer payment plan may need additional time to obtain group health coverage or adopt a suitable alternative.

The SHOP Marketplace addresses many of the concerns of small employers. However, because the market is still transitioning and the transition by eligible employers to SHOP Marketplace coverage or other alternatives will take time to implement, this guidance provides that the excise tax under Code § 4980D will not be asserted for any failure to satisfy the market reforms by employer payment plans that pay, or reimburse employees for individual health policy premiums or Medicare part B or Part D premiums (1) for 2014 for employers that are not ALEs for 2014, and (2) for January 1 through June 30, 2015 for employers that are not ALEs for 2015. After June 30, 2015, such employers may be liable for the Code § 4980D excise tax.

For purposes of this Q&A-1, an ALE generally is, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. See

Code § 4980H(c)(2) and §§ 54.4980H-1(a)(4) and -2. For determining whether an entity was an ALE for 2014 and for 2015, an employer may determine its status as an applicable large employer by reference to a period of at least six consecutive calendar months, as chosen by the employer, during the 2013 calendar year for determining ALE status for 2014 and during the 2014 calendar year for determining ALE status for 2015, as applicable (rather than by reference to the entire 2013 calendar year and the entire 2014 calendar year, as applicable). See section IX.E of the preamble to the proposed regulations under § 4980H (78 FR 218, 238) (Jan. 2, 2013) and section XV.D.3 of the preamble to the final regulations under § 4980H (79 FR 8544, 8573) (Feb. 12, 2014).

Employers eligible for the relief described in this Q&A-1 that have employer payment plans 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) solely as a result of having such arrangements for the period for which the employer is eligible for the relief. This relief does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums.

Question 2 (Treatment of S corporation healthcare arrangements for 2-percent shareholder-employees): IRS Notice 2008-1, 2008-2 I.R.B. 1, provides that if an S corporation pays for or reimburses premiums for individual health insurance coverage covering a 2-percent shareholder (as defined in Code § 1372(b)(2)), 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. (This arrangement is referred to in this notice as a 2-percent shareholder-employee healthcare arrangement.) Is a 2-percent shareholder-employee healthcare arrangement subject to the market reforms?

Answer 2: 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, and in any event through the end of 2015, the excise tax under Code § 4980D will not be asserted for any failure to satisfy the market reforms by a 2-percent shareholder-employee healthcare arrangement. Further, unless and until additional guidance provides otherwise, an S corporation with a 2-percent shareholder-employee healthcare arrangement will not be 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) solely as a result of having a 2-percent shareholder-employee healthcare arrangement.

The guidance provided in this Q&A-2 (including the guidance provided in the preceding paragraph) does not apply to reimbursements of individual health insurance coverage with respect to employees of an S corporation who are not 2-percent shareholders (but see Q&A-1).

The Treasury Department and the IRS are also considering whether additional guidance is needed on the federal tax treatment of 2-percent shareholder-employee healthcare arrangements. However, unless and until additional guidance provides otherwise, taxpayers may continue to rely on Notice 2008-1 with regard to the tax treatment of arrangements described therein for all federal income and employment tax purposes. To the extent that a 2-percent shareholder is allowed both the deduction under Code § 162(l) and the premium tax credit under Code § 36B, Revenue Procedure 2014-41, 2014-33 I.R.B. 364, provides guidance on computing the deduction and the credit with respect to the 2-percent shareholder.

Code § 9831(a)(2) provides that the market reforms do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year. Accordingly, an arrangement covering only a single employee (whether or not that employee is a 2-percent shareholder-employee) generally is not subject to the market reforms whether or not such a reimbursement arrangement otherwise constitutes a group health plan. If an S corporation maintains more than one such arrangement for different employees (whether or not 2-percent shareholder-employees), however, all such arrangements are treated as a single arrangement covering more than one employee so that the exception in Code § 9831(a)(2) does not apply. For this purpose, if both a non-2-percent shareholder employee of the S corporation and a 2-percent shareholder employee of the S corporation are receiving reimbursements for individual premiums, the arrangement would be considered a group health plan for more than one current employee. However, if an employee is covered under a reimbursement arrangement with other-than-self-only coverage (such as family coverage) and another employee is covered by that same coverage as a spouse or dependent of the first employee, the arrangement would be considered to cover only the one employee.

Question 3 (Integration of Medicare premium reimbursement arrangement and TRICARE-related HRA with a group health plan): If an employer offers to reimburse Medicare premiums for its active employees, does this arrangement create an employer payment plan under Notice 2013-54? If so, may the employer payment plan be integrated with another group health plan to satisfy the annual dollar limit and preventive services requirements? Similarly, does an arrangement under which an employer reimburses (or pays directly) some or all of medical expenses for employees covered by TRICARE constitute an HRA subject to the market reforms? If so, may the HRA be integrated with another group health plan to satisfy the annual dollar limit and preventive services requirements?

Answer 3: Medicare premium reimbursement arrangements. An arrangement under which an employer reimburses (or pays directly) some or all of Medicare Part B or Part D premiums for employees constitutes an employer payment plan, as described in Notice 2013-54, and if such an arrangement covers two or more active employees, is a group health plan subject to the market reforms. An employer payment plan may not be integrated with Medicare coverage to satisfy the market reforms because Medicare coverage is not a group health plan. However, an employer payment plan that pays for

or reimburses Medicare Part B or Part D premiums is integrated with another group health plan offered by the employer for purposes of the annual dollar limit prohibition and the preventive services requirements 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. Note 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. An employer payment plan that has fewer than two participants who are current employees (for example, a retiree-only plan) on the first day of the plan year is not subject to the market reforms and, therefore, integration is not necessary to satisfy the market reforms.

TRICARE-related HRAs. Similarly, an arrangement under which an employer reimburses (or pays directly) some or all of medical expenses for employees covered by TRICARE constitutes an HRA, and, as provided in Notice 2013-54, if such an arrangement covers two or more active employees, is a group health plan subject to the market reforms. An HRA may not be integrated with TRICARE to satisfy the market reforms because TRICARE is not a group health plan for integration purposes. However, an HRA that pays for or reimburses medical expenses for employees covered by TRICARE is integrated with another group health plan offered by the employer for purposes of the annual dollar limit prohibition and the preventive services requirements if (1) the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value; (2) the employee participating in the HRA is actually enrolled in TRICARE; (3) the HRA is available only to employees who are enrolled in TRICARE; and (4) the HRA is limited to reimbursement of cost sharing and excepted benefits, including TRICARE supplemental premiums. Note that to the extent such an arrangement is available to active employees, employers should be aware of laws that prohibit offering financial or other incentives for TRICARE-eligible employees to decline employer-provided group health plan coverage, similar to the Medicare secondary payer rules.

Note that an employer may provide more than one type of healthcare arrangement for its employees (for example, a Medicare Part B employer payment plan and a TRICARE-related HRA), provided that each arrangement meets the applicable integration or other rules set forth in this notice or in related guidance.

Question 4 (Increases in employee compensation to assist with payments of individual market coverage): If an employer increases an employee's compensation, but does not condition the payment of the additional compensation on the purchase of health coverage (or otherwise endorse a particular policy, form, or issuer of health insurance), is this arrangement an employer payment plan?

Answer 4: No. As described in Notice 2013-54, an employer payment plan is 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 or directly pays a premium for an individual health insurance policy covering the employee, such as arrangements described in Rev. Rul. 61-146. The arrangement described in this Q&A-4 does not meet that description. In addition, because the arrangement described in this Q&A-4 generally will not constitute a group health plan, it is not subject to the market reforms.[4] Providing employees with information about the Marketplace or the premium tax credit under Code § 36B is not endorsement of a particular policy, form, or issuer of health insurance.

Question 5 (Treatment of an employer payment plan as taxable compensation): Notice 2013-54 provides that the payment arrangement described in Rev. Rul. 61-146 is an employer payment plan. May the reimbursements or payments under an arrangement described in Rev. Rul. 61-146 be provided on an after-tax basis and, if so, will this cause the arrangement not to be a group health plan (and accordingly not to be subject to the market reforms)?

Answer 5: No. Rev. Rul. 61-146 holds that under certain conditions, if an employer reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance, the payments are excluded from the employee's gross income under Code § 106. This exclusion also applies if the employer pays the premiums directly to the insurance company. The holding in Rev. Rul. 61-146 continues to apply, meaning only that payments under arrangements that meet the conditions set forth in Rev. Rul. 61-146 are excludable from the employee's gross income under Code § 106 (regardless of whether the employer includes the payments as wage payments on the Form W-2). However, Rev. Rul. 61-146 does not address the application of the market reforms and should not be read as containing any implication regarding the application of the market reforms. As explained in Notice 2013-54, an arrangement under which an employer provides reimbursements or payments that are dedicated to providing medical care, such as cash reimbursements for the purchase of an individual market policy, is itself a group health plan. Accordingly, the arrangement is subject to the market reform provisions of the Affordable Care Act applicable to group health plans without regard to whether the employer treats the money as pre-tax or post-tax to the employee. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will fail to satisfy PHS Act §§ 2711 (annual limit prohibition) and 2713 (requirement to provide cost-free preventive services) among other provisions.

[4] For more information on establishing or maintaining a group health plan under ERISA, see 29 CFR 2510.3-1(j) and the Department of Labor's Field Assistance Bulletins Nos. 2006-2 and 2004-1, available at http://www.dol.gov/ebsa/regs/fab2006-2.html and http://www.dol.gov/ebsa/regs/fab2004-1.html.

III. FOR FURTHER INFORMATION

Questions concerning the information contained in this notice may be directed to the IRS at 202-317-6846. Additional information for employers regarding the Affordable Care Act is available at www.healthcare.gov,www.dol.gov/ebsa/healthreform, and at www.business.usa.gov.

IV. DRAFTING INFORMATION

The principal author of this notice is Shad Fagerland of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Mr. Fagerland at (202) 317-5500 (not a toll-free call).

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXII)

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

[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

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

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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).

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.

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[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.

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.

[12] See 29 CFR 2510.3-1(j).