PART II: IMPACT OF HEALTHCARE REFORM ON EMPLOYER FRINGE BENEFITS

Fringe Benefit Tax Planning

108. Why should employers verify whether they have a grandfathered health plan?

Grandfathered health plans are discussed in detail in Part VI of this book. They offer a way to avoid the health insurance nondiscrimination rules. An employer is eligible to implement a simple cafeteria plan if, during either of the preceding two years, the business employed 100 or fewer employees on average (based on business days). For a new business, eligibility is based on the number of employees the business is reasonably expected to employ on average (based on business days). Businesses maintaining a simple cafeteria plan that grow beyond 100 employees can maintain the simple arrangement until they have exceeded an average of 200 or more employees during a preceding year.

For many employers, the most important benefit is that an employer's grandfathered health insurance plan will not be subject to the new health insurance nondiscrimination rules, discussed in detail in Part VII of this book. When those rules go into effect, if an insured plan discriminates in favor of the top 25 percent of highly compensated employees (HCEs), for example, by paying more of the premiums, then there will be a $100 per day per employee penalty for the employer based on the number of non-highly compensated employees (NHCEs). For an employer with twenty-eight employees, violation of the nondiscrimination rules could result in a penalty of $766,500!

*Example:* The employer’s grandfathered plan is in effect for the entire year, and twenty-one participants are not highly compensated employees.

21 NHCEs x $100 = $2,100 penalty per day

$2,100 x 365 days = $766,500

Thus, for employers that have had their plan since March 23, 2010, have made few if any changes, and provide better benefits or pay more for HCEs, a careful review of the grandfathered plan requirements should be done before any changes are made to the plan.

109. Why should an eligible employer consider a SIMPLE cafeteria plan?

The SIMPLE cafeteria plan is discussed in detail in Part V of this book. The 2010 health reform law includes a provision creating “simple cafeteria plans” for small businesses, effective for years beginning in 2011. Simple cafeteria plans will be treated as meeting nondiscrimination requirements applicable to cafeteria plans if they meet minimum eligibility, participation, and contribution requirements. This safe harbor covers the regular cafeteria plan nondiscrimination requirement of Code section 125(b) (the provision that limits benefits to key employees to 25 percent of the plan's benefits) and also the nondiscrimination requirements of Code sections 79(d), 105(h), and 129(d), which are applicable to group term life insurance, a self-insured health or medical reimbursement plan, and dependent care assistance benefits (child care), respectively.

One of the changes proposed in the original legislation drafted by the Small Business Council of America was not adopted. When a business wants to avoid the 25 percent concentration test and contribute for owner-employees, only a regular C corporation can do so. The provisions for simple cafeteria plans apply to "employees," but the term excludes proprietors, partners, LLC members in LLCs taxed as partnerships, and more than 2 percent shareholders in S corporations, all of whom are self-employed individuals and not employees for income tax purposes.

Simple cafeteria plans, available for plan years beginning in 2011, offer a work-around to the new health insurance nondiscrimination rules applicable to all employer-sponsored plans other than grandfathered plans. In addition, these plans allow shareholder-employees and other key employees to benefit under the plan and be exempt from the regular cafeteria plan rule that limits benefits for such individuals to 25 percent of the total nontaxable plan benefits (the so-called concentration test). Additionally, a simple cafeteria may allow key employees to have greater dependent care reimbursement than otherwise available in a regular cafeteria plan.

It would seem safe for the employer to proceed on the basis that the health insurance nondiscrimination rules are met when the plan provides the same eligibility and offers the same benefit options for all participants. Even if all HCEs take family coverage (and it was available on an equal basis and equal contribution level for NHCEs) and all NHCEs took single or none, then the employer should still pass.

110. What are the limits on health FSAs in cafeteria plans (also called flex plans)?

A health FSA is a flexible spending account (FSA), typically part of a cafeteria plan, that reimburses participants from their pre-tax salary deferrals for medical and dental expenses. The deferrals are not reported as taxable income and the reimbursement is not taxable. In effect, the expenses are paid with pre-tax dollars. Prior to 2013, there was no limit on such accounts except those the employer imposed on the plan. It has not been unusual for such health FSAs to be available in amounts of $5,000, $10,000, and sometimes more. The health reform law limits the annual reimbursement from health FSAs to $2,500 per year, as a revenue raiser to help pay for the law's new costs. The details of this rule are discussed in Part VIII of this book.

Plans must be amended to provide for this new limit. The $2,500 limit does not apply to dependent care (child care) FSAs, adoption assistance FSAs, or health insurance premium conversion plan elections, where salary deferrals can be used to pay an employee's share of health insurance with pre-tax dollars.

111. Is a MERP, HRA, FSA, HSA, employer payment plan or cafeteria plan subject to the prohibition on annual and lifetime dollar limits or the preventive care requirements?

PHSA section 2711, effective in 2014 and discussed in Part VII, prohibits annual and lifetime dollar limits by group health plans on essential health benefits by group health plans and individual insurance policies, including grandfathered plans and policies.[[1]](#footnote-1) Annual or lifetime dollar limits can be imposed on benefits that are not essential health benefits.[[2]](#footnote-2) PHSA section 2713 requires that group health plans pay or reimburse preventive care with no out of pocket costs by the group health plan participant. Healthcare reform also adds new ERISA section 715 and new Code section 9815, which impose the PHSA mandates not only on group health plans but also on health insurance issuers. The penalty for violating PHSA section 2711 is an excise tax under Internal Revenue Code section 4980D of $100 per day ($36,500 per year) per affected individual (per participant) for violating the Chapter 100 requirements, including Code section 9815, which incorporates the PHSA mandates. The first government guidance concerned whether these plans are group health plans and whether they must comply with the no annual dollar limit rule.

Group Health Plan. ERISA and the PHSA define “group health plan” in virtually identical language, providing that the term means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents directly or through insurance, reimbursement, or otherwise.[[3]](#footnote-3) The Tax Code’s definition is broader. Under the Code, a group health plan is “a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.[[4]](#footnote-4) The Code's definition, unlike the ERISA definition, does not depend on the arrangement being an ERISA welfare benefit plan, and explicitly includes a plan contributed to by a self-employed person if there are at least two plan participants. which includes either common law employees or self-employed individuals (partners, proprietors, 2 percent of more S corporation shareholders, etc.)

An HRA or MERP that is a group health plan is subject to the 90-day waiting period maximum requirement of PHSA section 2708 beginning in 2014.

HRA/MERP. IRS guidance specifically confirms that, generally, health reimbursement accounts (HRAs) and their cousin, medical expense reimbursement accounts (MERPs), both of which are funded with employer contributions, are generally group health plans.[[5]](#footnote-5) Group health plans generally are subject to the PHSA section 2711 prohibition on annual/lifetime dollar limits in 2014 and thereafter. However, the initial guidance indicated that four types of HRAs are exempt from PHSA and can continue in 2014 and thereafter:

* A stand-alone HRA or MERP that is limited to one participant or retiree is not subject to the PHSA section 2711 annual/lifetime dollar limit restrictions.[[6]](#footnote-6) Such HRAs are not group health plans because they do not cover two or more employees.[[7]](#footnote-7) .
* A plan is not an ERISA welfare benefit plan if it covers only individuals who own, or whose spouses own, an interest in an unincorporated business (as partner or proprietor). It is not a plan subject to federal regulation, but ERISA does apply if one or more common law employees is a participant.[[8]](#footnote-8) If a corporation is wholly owned by an individual (or by an individual and his or her spouse), a plan that does not cover any other employee is also exempt from ERISA.[[9]](#footnote-9) Accordingly, the incorporation of a sole proprietorship does not affect ERISA's coverage, but the incorporation of a partnership usually does because there will be shareholders who are not spouses of one another. However, these plans are rare, as there is no income tax benefit to them for the partners. In addition, while not ERISA group health care plans, they are group health plans for the Code, so in effect this exception is no exception at all.
* HRAs that are or provide for excepted benefits (vision and dental coverage) are exempt from the annual/lifetime dollar limit prohibition.[[10]](#footnote-10) The regulators have confirmed that the HIPAA excepted benefits provisions apply for the PHSA mandates, including those in the PHSA itself (applicable to insurers and governmental employers) and as incorporated into ERISA and the Code.[[11]](#footnote-11)
* Finally, HRAs that are integrated with other major medical coverage as part of a group health plan will not violate the annual limit rules so long as the other coverage on its own would comply “because the combined benefit satisfies the requirements.”[[12]](#footnote-12)

Later agency guidance[[13]](#footnote-13) also explains how the ban on annual dollar limits in health plans and, in addition, the first-dollar preventive care coverage mandate applies to the following arrangements:

* HRAs that are group health plans, including those integrated with a group health plan
* Group health plans under which an employer reimburses an employee for health insurance premiums, or arrangements where the employer pays an employee’s premium for an individual health policy (collectively, an employer payment plan)
* Certain FSAs
* Employee assistance programs (EAPs)

The guidance generally applies for plan years beginning on and after January 1, 2014.

Stand-alone HRAs/MERPs that do not satisfy the definition of “integrated” cannot continue beyond 2014 unless they cover only retirees or only one employee (an owner for this purpose is an employee), are limited to excepted benefits, or have no annual or lifetime dollar limit and cover all preventive care with no copays or deductibles (which could expose an employer to substantial, perhaps devastating, liability). The agencies have provided limited transition relief for HRAs in existence prior to January 1, 2013, for amounts accrued prior to January 1, 2014. To qualify for the transition relief, the accrued amounts must be made pursuant to a formula established prior to January 1, 2013, or, if there is no formula, must be less than the amounts accrued in 2012.[[14]](#footnote-14)

The later agency guidance[[15]](#footnote-15) provides two ways of integrating HRAs (including MERPs) with group health plans so that these requirements are met. Neither method requires that the HRA and associated coverage share the same plan sponsor, plan document or governing instruments, or that they file a single Form 5500.

Integration Method 1: Minimum Value Not Required

To integrate an HRA with another group health plan for both the annual dollar limit prohibition and preventive services rule, the following requirements must be satisfied:

* The employer’s group health plan provides more than excepted benefits.
* The HRA participant is actually enrolled in the group health plan that is integrated with the HRA or a spouse’s employer’s group health plan.
* The HRA is available only to employees also enrolled in non-HRA group coverage (which might be a group health plan offered by another employer, such as a spouse’s employer).
* The HRA is limited to reimbursing one or more of the following: copayments, coinsurance, deductibles and premiums under the non-HRA group coverage, as well as medical care that does not constitute essential health benefits.
* Under the HRA, employees (or former employees) may permanently opt out of and waive future reimbursements from the HRA at least annually and, upon terminating employment, either forfeit the HRA balance or opt out of and waive future HRA reimbursements. By opting out of HRA coverage, individuals may preserve their eligibility for a federal premium tax credit.

*Example:* Employer A sponsors a group health plan and an HRA, which meets the above conditions. Employer A employs Employee X, who enrolls in non-HRA group coverage sponsored by Employer B, his spouse’s employer. Employer A and Employer B are not treated as a single employer, and Employee X informs Employer A that he is covered by Employer B’s non-HRA group coverage.

When seeking reimbursement under Employer A’s HRA, Employee X attests that the expense is a copayment, coinsurance, deductible or premium under Employer B’s group health plan or medical care that is not an essential health benefit.

Employer A’s HRA is “integrated” with Employer B’s group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements, so the HRA does not violate those mandates.

Integration Method 2: Minimum Value Required

An HRA that does not limit reimbursements may be integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if the following conditions are met:

* The employer offers a group health plan that provides minimum value under the PPACA.
* The HRA participant is enrolled in a group health plan that provides minimum value, whether or not it is an employer-sponsored plan.
* The HRA is available only to employees who are enrolled in non-HRA minimum value group coverage (whether or not it is an employer-sponsored plan).
* Under the HRA, the employee (or former employee) may permanently opt out of and waive future HRA reimbursements at least annually, and, upon termination of employment, the employee may either forfeit the remaining balance or opt out of the HRA and waive future reimbursements.

*Example:* Employer A sponsors a group health plan that provides minimum value and also sponsors an HRA, which meets the conditions above. Employer A employs Employee X. Employee X enrolls in a non-HRA group health plan sponsored by Employer B, his spouse’s employer.

Employer A and Employer B are not treated as a single employer, and Employee X attests to Employer A that he is covered by Employer B’s group plan that provides minimum value coverage. Employer A’s HRA is integrated with Employer B’s group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements.

Unused HRA Amounts. If the plan permits, unused HRA amounts that were credited while the HRA was integrated with other group health plan coverage may be used to reimburse medical expenses incurred even after the employee is no longer covered by the other integrated group health plan. Unless the coverage consists entirely of excepted benefits, coverage provided through an HRA constitutes an eligible employer-sponsored plan and thus minimum essential coverage under the individual mandate.

Group Health Plans and Essential Health Benefits. An HRA integrated with a group health plan will generally violate the prohibition on annual dollar limits if the HRA covers a category of essential health benefits not covered by the group health plan and limits the coverage to the HRA’s maximum benefit. Under the minimum value required integration method, however, as long as a group health plan provides minimum value, the integrated HRA will not violate the prohibition on annual limits.

Health savings accounts (HSAs) are not subject to the PHSA rule prohibiting annual and lifetime dollar limits or the preventive care rules.

A health savings account (HSA) is a tax-favored individual account vehicle for paying medical expenses.[[16]](#footnote-16) An HSA may be used only in conjunction with a high-deductible health plan (HDHP). An HSA may be established by an employee (with or without employer involvement), and contributions may be made by the employee, the employer, or both. The DOL has stated that HSAs are not ERISA employee welfare benefit plans even if funded by the employer.[[17]](#footnote-17) Similarly, the preamble to the DOL/HHS/IRS) HIPAA portability regulations notes that “the HIPAA portability requirements generally are not relevant for purposes of HSAs.”[[18]](#footnote-18) Therefore, HSAs will not be group health plans for the PHSA mandate.

Health Flexible Spending Accounts. Health FSAs meeting two conditions, which most of them meet, are excepted benefits and thus not required to comply with the PHSA mandates.[[19]](#footnote-19) First, the maximum benefit payable under the health FSA to any participant in the class for a year cannot exceed two times the participant’s salary reduction election under the health FSA for the year (or, if greater, the amount of the participant’s salary reduction election for the health FSA for the year, plus $500).[[20]](#footnote-20) Thus, the maximum health FSA annual benefit where the participant makes the maximum annual $2,500 salary reduction contribution means that the employer can contribute up to $500 per year to the health FSA.[[21]](#footnote-21) IRS officials have informally indicated that for purposes of the maximum benefit condition, benefits provided during a grace period from the prior year’s contributions are attributed to the prior year. Second, other nonexcepted group health plan coverage (major medical coverage) must be made available for the year to the class of participants by reason of their employment.[[22]](#footnote-22) Finally, interim final regulations jointly issued by the IRS, DOL, and HHS on the annual and lifetime limits (the “joint regulations”) appear to go further, exempting any plan that is a health FSA within the meaning of Code section 106(c)(2), even if it does not satisfy the two additional conditions for the HIPAA exception, so long as the amount of available reimbursement is less than 500 percent of the value of such coverage.[[23]](#footnote-23)

Notwithstanding the foregoing, health FSAs cannot be used to reimburse the costs of health insurance.[[24]](#footnote-24) A health FSA is a plan that reimburses medical costs that the health plan does not pay, whether due to co-pays, deductibles or otherwise. As a practical matter, beginning in 2014, an employer cannot offer a standalone FSA. It can only be offered to employees who are offered qualifying group medical coverage, whether or not they elect to take it.[[25]](#footnote-25)

Employee Assistance Plans. EAPs generally are considered to provide excepted benefits as long as they do not provide significant medical or treatment benefits; thus, in most cases they do not constitute minimum essential coverage and will not need to meet the prohibition on an annual limit or preventive care requirements.

Employer Payment Plan. Notice 2013-54 coins the term employer payment plan and states that pre-tax dollar reimbursement plans for individual health insurance are not permitted, commencing in 2014. There is no explanation as to why the tax status of the reimbursement is relevant, but perhaps it is because an after-tax reimbursement is the equivalent of a compensation increase, something that is clearly permitted to replace employer health benefits that are eliminated. An employer payment plan, as the term is used in this notice, 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. If read literally however, it would include a plan where an employer, on an after tax basis, only reimburses employees who purchase individual health insurance but does not give them an option to elect a cash payment if they do not.

Cafeteria Plans. There is no question that either employer or employee elective deferral contributions can be used to purchase or reimburse employee payments for group health insurance if the cafeteria plan requirements are met. However, while there is an argument that a cafeteria plan can be used to reimburse individual health insurance, other than exchange purchased insurance, the issue not entirely clear. Read literally the requirements indicate that it cannot be so used. As noted above, the Tax Code defines a group health plan as a plan “of, or contributed to by, an employer.” Even if the premiums for individual policies are reimbursed solely by employee elective deferrals, for tax purposes, they are employer contributions and are used to reimburse health insurance costs and thus are a group health plan. An argument, based on statutory interpretation, can be made that elective deferrals can be used to pay for individual non-exchange purchased policies because healthcare reform amended section 125 of the tax code to prohibit the use of cafeteria plans to fund individual, exchange‐based coverage. This suggests that purchases of individual insurance policies is otherwise permitted through a cafeteria plan. If it was impermissible to pay for such individual policies through a cafeteria plan, there would be no need to amend section 125 for individual, exchange‐based policies. Healthcare reform amends section 125 of the tax code to provide that insurance purchased through a state exchange may not be funded through a cafeteria plan unless the individual’s employer is eligible to participate in the SHOP exchange and elects to make group coverage available to employees through the exchange. An employer is exchange‐eligible if it averages fewer than 100 full‐time employees during the year, or fewer than 50 full‐time employees at the state’s election.[[26]](#footnote-26) Nevertheless, if the cafeteria plan is found to be a “group health plan” because it reimburses health insurance, it will fail both the preventive care and annual limit prohibition rules even if, illogical as it may be, the plan funds are used to purchase insurance that does comply.

112. Are strategies promoting employers reimbursing employees for the purchase of individual health insurance approved by the IRS?

No. As discussed above, in IRS Notice 2013-54 issued last year and confirmed in May 2014,[[27]](#footnote-27) the Internal Revenue Service issued a warning that employer health reimbursement arrangements that attempt to reimburse employees for the purchase of individual health insurance with “pre-tax dollars,” i.e., payments deductible to the employer and nontaxable to the employee are not permitted. Nevertheless, it has been reported that several organizations are promoting such employer pre-tax health insurance reimbursement plans.[[28]](#footnote-28)

The IRS has reaffirmed the guidance of Notice 2013-54:

“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.”[[29]](#footnote-29)

The issue involves the healthcare law requirement effective in 2014 that there be no annual dollar limits[[30]](#footnote-30) on the coverage for a person’s basic medical needs, which the law calls essential health benefits. As noted above, the IRS clearly has stated that a plan reimbursing employees on a pre-tax basis for insurance they buy on their own cannot comply with this ACA prohibition on annual limits because the company’s contribution is by definition limited, even if the health insurance the employee purchases has no annual limits. Second, the technical argument that insurance premiums are not essential health benefits (“EHBs”) and therefore are not subject to the annual limit rule only addresses one issue. These pre-tax reimbursement plans also violate the preventive care mandate (the obligation to provide unlimited, no-cost coverage for specified preventive-care benefits[[31]](#footnote-31)), which mandate does not depend on whether the plan otherwise covers EHBs. The penalty for violating either the no annual limit or preventive care rule is $36,500 per participant per year,[[32]](#footnote-32) not to exceed $500,000 per year or, if less, 10 percent of the cost of the employer’s group health plan for the year if the employer can demonstrate that noncompliance was due to reasonable cause.[[33]](#footnote-33)

113. Are executive physical and executive diagnostic reimbursement plans still available under Healthcare reform?

Notice 2013-54 does not alter Rev. Rul. 61-146, which allows the payment of medical expenses income tax-free to employees with employer deductible dollars. Additionally, the logic of Notice 2013-54 is helpful because it provides that Employee Assistance Plans are not subject to healthcare reform as long as they do not provide significant benefits in the nature of medical care or treatment. Excluding executive diagnostic and physical programs from healthcare reform requirements is therefore consistent with the treatment of EAPs under Notice 2013-54.

So-called executive diagnostic reimbursement plans have existed for decades under the tax law and provide employers with the ability to reimburse employees for expenses not paid by their health plans. However, such plans, even if in place on March 23, 2010 and grandfathered from certain healthcare reform requirements, must still comply with certain healthcare reforms. Newer plans that are not grandfathered must comply with more reforms or face a fine of $36,500 per year per participant. All such plans, including grandfather plans, must cover preventive care without any deductible or annual or lifetime limit. Thus, grandfathered executive reimbursement plans should be amended to so provide.

Preventive care must be offered without charge and without dollar limit and is defined as care provided to a person when healthy, such as routine physicals, check-ups, screenings, and immunizations. Certain so-called self-funded “executive medical reimbursement plans” can be offered by employers on a discriminatory basis. While the tax regulations regarding permissible discriminatory employer medical reimbursement plans use the term “diagnostic reimbursement plans”, they actually describe preventative care, not diagnostic care, as those terms are defined by healthcare reform. It is not totally free from doubt whether covering all of the items required by PHSA 2713 would fall within the definition of a “plan for medical diagnostic procedures” under IRS regulation section 1.105-11(g)(1) for these plans. However, that regulation describes the same things as what healthcare reform describes as preventive care but not diagnostic care. Preventive care is not for treatment, cure, diagnosis, or testing of a known condition, complaint, or symptom, but preventive care is medical care under Internal Revenue Code section 213, as opposed to items merely beneficial to general health.

A discriminatory executive reimbursement plan intended to provide pre-tax dollar benefits (deductible to the employer and not taxed to the employee) is limited solely to employees and cannot include dependents or spouses. This benefit is deductible to the employer and not taxed to the employee under the regular tax rules governing employer paid health plans. However, it is available solely for “employees” under the tax law. Thus, it is available to employees who are not owners or owners who are shareholders and employees of a regular “C” corporation but not partners, proprietors, more than 2 percent S corporation shareholders, or other self-employed individuals.

The (1) prohibition of an annual dollar-limit on essential benefits and (2) the requirement to cover preventive care without cost sharing affects arrangements that constitute “group health plans” and do not apply to “excepted benefits.” A discriminatory preventive care reimbursement plan would be a group health plan and not an excepted benefit. Thus, it is subject to the expanded healthcare reform requirements, including the claims procedures requirements. It would need annually to distribute a summary of benefits and coverage. It cannot be limited to physicals but must cover all preventive care services because it would be subject to the no annual dollar limit requirement. From a drafting perspective, the plan should state that it is not limited to the procedures specifically described in Reg. section 1.105-11(g) but covers all PHSA preventive care requirements. Notice 2013-54 states that if a group health plan is not an excepted benefit, then it is required to comply with all the PHS Act mandates. Failure to do so exposes the employer to the $100/day/participant excise tax.

Seemingly, but again not completely free from doubt, the executive reimbursement plan is not subject to the tax rules governing HRAs, i.e., self-insured health reimbursement accounts, also called medical expense reimbursement plans. While an HRA cannot be available to employees unless they are covered by the employer or spouse’s comprehensive medical plan, it would seem that the so-called diagnostic reimbursement plan under Reg. section 1.105-11(g) could be offered on a standalone basis because it is not an HRA. Unlike the normal HRA, there is no account for an employee or maximum annual dollar limit because the preventive care benefit cannot have an annual dollar limit.

The so-called discriminatory executive reimbursement plan does not cause an employer’s high deductible health plan to cease to be a high deductible plan, which is a requirement for maintaining a health savings account. There is a specific exception in the Tax Code’s definition of a high deductible plan for preventive care services. Additionally, Notice 2013-57 provides that the preventive care required under PHSA 2713 without any deductible does not cause a plan to fail to be an HDHP. While this type of a plan is an employer funded stand-alone plan, and not part of a HDHP), the same rationale of Notice 2013-57 applies.

Preventive Care, Diagnosis & Treatment. Under healthcare reform, diagnosis and treatment are different from preventive care and need not be provided free of charge. They involve testing or treatment for a symptom or health issue, such as an existing illness or injury. Services are diagnostic care when:

* Services are ordered due to current issues or symptoms(s) that require further diagnosis.
* Abnormal test results on a previous preventive or diagnostic screening test requires further diagnostic testing or services.
* Abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guideline recommendations would require.

If preventive care is offered free of charge by in-network providers, cost sharing can be imposed if the participant elects more expensive in-network options, or seeks services which are out of network.

Preventive services and tests are as follows:

Adults and Children

* Routine physical examinations
* Alcohol misuse screening and counseling (primary care visits only, beginning at age 11)
* Cholesterol screening
* Depression screening (adults, children ages 12-18, primary care visits only)
* Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians)
* Hemoglobin A1c
* Hepatitis B testing
* Immunizations, including flu shots (flu shots at age 19 and above at a doctor’s office or pharmacy; under age 19 at a doctor’s office)
* Obesity screening and counseling (adults and children, in primary care settings)
* Sexually transmitted diseases (STDs) – screenings and counseling (adolescents, adults, and pregnant women)
* Tobacco use screening and counseling, including smoking cessation counseling and FDA-approved nicotine replacement therapy (primary care visits only)
* Total cholesterol tests

Adults Only

* Aspirin for the prevention of heart disease when prescribed by a health care provider
* Blood pressure screening (adults without known hypertension)
* Colorectal cancer screening, including colonoscopy, sigmoidoscopy, and fecal occult blood test
* Diabetes screenings
* HIV screening and counseling
* Vitamin D supplements for the prevention of falls when prescribed by a health care provider to community-dwelling members beginning at age 65

Women Only

* BRCA 1 or 2 genetic counseling, evaluation and testing for women with a family history associated with increased risk of mutation
* Breast cancer chemoprevention (counseling only for women at high risk for breast cancer and low risk for adverse effects of chemoprevention)
* Breast cancer screening, including mammograms and counseling for genetic susceptibility screening
* Breastfeeding primary care interventions (applicable to pregnant women and new mothers), including electric and manual breast pumps, lactation classes and support at prenatal and post-partum visits, and newborn visits
* Cervical cancer screening, including pap smears
* Comprehensive lactation support, counseling, and costs of renting breastfeeding equipment
* Contraceptive methods approved by the FDA, sterilization procedures and contraceptive patient education and counseling (contraceptives covered with no member cost sharing include generics and brand name drugs with no generic alternative, including emergency contraceptives.)
* Folic acid supplements (women planning or capable of pregnancy only)
* Gestational diabetes screening
* HPV (human papillomavirus) testing
* Interpersonal and domestic violence counseling and screenings
* Iron deficiency anemia (pregnant women at prenatal visits)
* Microalbuminuria test (pregnant women)
* Osteoporosis screening (screening to begin at age 50 for women at increased risk)
* Ovarian cancer susceptibility screening
* Over the counter contraceptive items such as sponges and spermicides, when prescribed by a health care provider
* Rh (D) incompatibility, screening (pregnant women)
* Routine OB/GYN examinations
* Routine outpatient prenatal and postpartum visits

Children Only

* Autism screening (for children between 18 and 24 months of age; primary care settings)
* Behavioral assessments (children of all ages; developmental surveillance, in primary care settings)
* Congenital hypothyroidism (screening for newborns only)
* Dental prevention – oral fluoride (for children to age 5 only) Note: Coverage for fluoride is only provided if your plan includes outpatient pharmacy coverage
* Dyslipidemia screening (for children at high risk for higher lipid levels)
* Hearing screening (screening for newborn only, primary care settings)
* Iron deficiency prevention (primary care counseling for children ages 6 to 12 months only)
* Lead screening (children at risk)
* Phenylketonuria screening (newborns before 7 days old)
* Sickle cell disease, screening (screening at birth and first newborn visit)
* Tuberculosis skin testing
* Vision screening (children to age 5 only)

Men Only

* Abdominal aortic aneurysm screening (for males 65-75 one time only, if a history of smoking)

114. Can an employer with employees in different states with different employer health insurance plans in each state integrate these plans with an employer funded Health Reimbursement Account (HRA)?

Assume that an employer has in-state employees and will soon have one out-of-state employee in Hawaii. The local medical insurance provider cannot cover this employee as it does not sell health insurance in Hawaii. The employee and employer have identified reasonable-cost coverage for the employee in Hawaii, offered by the Hawaii Medical Service Association. It is a small business plan for companies with less than fifty employees.

Can this employee and dependents be covered by the employer’s HRA or medical expense reimbursement plan (MERP) with annual dollar limits via integration with the Hawaii insurance plan?

Assume further that this employee will be the only employee of the employer covered by the Hawaii insurance plan. Q&A 4 of IRS Notice 2013-54 states that the employer’s HRA can be continued with the annual limit on benefits under PHS Act section 2711 as long as the HRA is integrated with a “group health plan” and is not integrated “with individual policies” or with “individual market coverage.”

Assuming the HRA is properly integrated with both insured health plans, this arrangement should be acceptable because it is part of an employer’s group plan with two sources for the employees’ medical insurance coverage.

115. Can HSA’s be combined with exchange-purchased High Deductible Health Insurance Plans (HDHP)?

A tax deductible HSA may be established by an employer for an “eligible individual” who, for any month: (1) is covered under a high-deductible health plan (HDHP) on the first day of the month; (2) is not also covered by any other non-HDHP health plan (with certain exceptions), including an FSA (except for dental. vision, preventive care, and general medical benefits only after the HDHP deductible is reached); (3) is not entitled to benefits under Medicare (has not yet reached age sixty-five); and (4) is not claimed as a dependent on another person's tax return.

IRS Notice 2013-54 prohibits pretax employer dollar payments to be integrated with exchange purchased insurance. HRAs and MERPs (employer funded cash medical reimbursement) thus violate the rule prohibiting annual dollar limits (with an annual per participant penalty of $36,500) unless employees are not limited to the annual or lifetime reimbursement they may claim from the employer under the employer’s plan, a risk most employers will not want to take.

Fortunately, neither health savings accounts (HSAs) nor most health flexible spending accounts (health FSAs), which cover medical reimbursement as part of a cafeteria or flex plan, are subject to the healthcare reform PHSA rule prohibiting annual and lifetime dollar limits. An employer could therefore contribute to an HSA for those employees who have a high deductible plan for the month of the employer contribution. Those eligible for an exchange purchased insurance subsidy will want to purchase their health insurance on an exchange. The question is whether one can get a high deductible plan on an exchange which will be an exchange-by-exchange determination. For anyone under age thirty, they can buy a “young invincible” catastrophic policy, which will likely not meet the high deductible definition because maximum out-of-pocket costs to qualify for an HSA cannot exceed stated amounts, which in 2014 is $6,5 50 for self-only coverage and $12,700 for family coverage. In 2015, maximum out-of-pocket amounts increase to $6,660 for self-only coverage and $12,900 for family coverage.[[34]](#footnote-34)

Anecdotal evidence suggests that the cost-sharing features of many exchange offered QHPs would allow them to qualify as HSA-eligible high deductible health plans. For example, there are platinum plans on the Kansas exchange with $1,500 individual deductibles, and the deductibles generally go higher in the gold, silver and bronze plans. In fact, at the bronze or silver levels, some plans are exceeding the $2,000/$4,000 limit on deductibles in the individual and small-group markets, which are allowed in order to meet the actuarial value (AV) level.

The HDHP minimum deductibles for 2014 are $1,250 individual and $2,500 family. All QHPs will meet the maximum out-of-pocket of $6,350 individual and $12,700 family. Notice 2013-57 confirms that first-dollar preventive care under PHSA 2713 won’t cause a plan to fail to be an HDHP. Thus, many exchange QHPs would be HSA-qualified.

There is nothing at the present moment that suggests that employers who provide HSA contributions for employees directly or through a cafeteria plan would be treated as providing coverage under an eligible employer-sponsored plan which would in turn render the employees ineligible for the 36B tax credit.

Two features of HDHPs that will be applied to all insurance plans include: (1) first-dollar coverage of preventive care (no copays or deductibles can apply), and (2) annual limits on out-of-pocket expenses. These two features have been a part of the HSA design since their inception. The most significant change brought by the ACA requires all insurance plan designs to cover, on average, 60 percent of the cost of benefits covered by the plan. Fortunately, even the highest deductible HSA-qualified plans can meet this standard. This means that HSA plans may be offered in each state health insurance exchange.

Of course, individuals can purchase high deductible health insurance on the individual market and not through an exchange, but if they do so they cannot qualify for a subsidy.

116. Must preventive services be provided by non-grandfathered HSA-eligible HDHPs?

IRS Notice 2013-57 states that high-deductible health plans (HDHPs) eligible to be linked with health savings accounts (HSAs) must cover all preventive services mandated under healthcare reform without imposing a deductible. Grandfathered HDHPs may elect to do the same.

Notice 2013-57 clarifies that, for purposes of the HDHP/HSA rules, preventive care not subject to deductibles may include all preventive services and benefits previously defined by the IRS as well as those required under the PPACA and will not jeopardize the HDHP’s health savings account (HSA) qualified status.

For HSA contributions to be tax favored, the employee must be covered under an HSA-qualifying HDHP and generally may not have other health coverage, although there are exceptions, such as stand-alone vision, dental, and long-term care coverage. For 2013 and 2014, annual deductibles in HSA-eligible HDHPs must be at least $1,250 for self-only coverage or $2,500 for family coverage, but now first-dollar and low-deductible coverage is allowed for preventive care. In 2015, the annual deductible in HSA-eligible HDHPs must be at least $1,300 for self-only coverage or $2,600 for family coverage.[[35]](#footnote-36)

The IRS considers some drugs and medications as excepted preventive care, and health care reform added others. IRS Notice 2004-23 lists the types of preventive care that need not be subject to the high deductible. Its nonexclusive list of safe-harbor preventive care services includes things not intended to treat an existing illness, injury, or condition:

* Periodic health evaluations, including tests and diagnostic procedures ordered in conjunction with a routine exam, such as an annual physical.
* Routine prenatal and well-child care.
* Child and adult immunizations.
* Tobacco-cessation programs, including prescription drugs.
* Obesity weight-loss programs, including prescription drugs.
* Screening services, such as for cancer, heart and vascular diseases, infectious diseases, mental health conditions and substance abuse, metabolic/nutritional/endocrine conditions, musculoskeletal disorders, obstetric/gynecological conditions, pediatric conditions, and vision and hearing disorders.
* The “All About HSAs” document on the Health Savings Account section of the IRS Web site (www.treas.gov/offices/public-affairs/hsa/) states that certain drugs and medications can be considered preventive care, such as drugs taken by a person who has developed risk factors for a disease that has not yet manifested itself, or to prevent reoccurrence of a disease. The example provided is cholesterol-lowering medication for individuals with high cholesterol.

All non-grandfathered group health plans, including HDHPs, must provide in-network coverage for mandated PPACA preventive services without participant cost sharing, namely:

* Evidence-based items or services that are rated “A” or “B” by the U.S. Preventive Services Task Force
* Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
* For infants, children and adolescents, evidence-informed preventive care and screenings in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)
* For women, preventive care and screenings provided in HRSA’s Women’s Preventive Services

117. May an employer reimburse the cost of Medigap insurance for those employees enrolled in Medicare?

No. If the employer has 20 or more participants in its health plan, it may not offer an economic incentive for employees to drop out of the health plan and elect to be covered by Medicare.[[36]](#footnote-37) If the employer has fewer than 20 participants in its health plan, that reimbursement would be a group health plan and would not meet the group health plan requirements. Further, the employer cannot exclude those eligible for Medicare from its group health plan.[[37]](#footnote-38)

118. What guidance has the IRS provided in regard to same-sex spouses and HSAs, cafeteria plans, health FSAs and DCAPs?

IRS Notice 2014-1provides guidance as a result of the U.S. Supreme Court’s *Windsor* decision for same-sex spouse benefits and addresses issues arising under cafeteria plans, health FSAs, DCAPs, and HSAs.

HSA Limits. Same-sex married couples are subject to the joint deduction limit for HSA contributions ($6,550 in 2014 and $6,660 in 2015 if either spouse has family HDHP coverage). If the spouses previously elected to make contributions to separate HSAs that will exceed the joint limit, contributions may be reduced as necessary for the remainder of the year. Any excess contributions may be distributed from the HSAs no later than the spouses’ tax return due date. Excess contributions not distributed by that date will be subject to excise taxes.

Cafeteria Plan Election Changes. Cafeteria plan election change rules allow participants to change plan elections midyear—e.g., to add health coverage for a spouse—if specified events occur, and if the change is consistent with the event. This election change guidance appears to apply to all cafeteria plan benefits, including health FSAs and DCAPs, so long as the consistency rules are met.

* *Change in marital status.* The guidance allows participants who were married to a same-sex spouse on June 26, 2013 (the date of the *Windsor* decision) to be treated as if they experienced a change in legal marital status for purposes of the cafeteria plan election change rules. Employees wishing to make election changes due to *Windsor* may do so at any time during the cafeteria plan year that includes either June 26, 2013 or December 16, 2013. Participants marrying a same-sex spouse after June 26, 2013 may also make election changes due to a change in marital status.
* *Significant change in cost of coverage.* According to the guidance, a change in a cafeteria plan benefit’s tax treatment generally does not constitute a significant change in the cost of coverage (and thus would not ordinarily be a proper basis for allowing an election change with respect to a same-sex spouse). However, given the legal uncertainty created by the *Windsor* decision, plans will not be treated as having failed to comply with the election change rules solely because they permitted midyear election changes on this basis between June 26 and December 31, 2013.
* *Effective date.* Election changes made under a cafeteria plan because of *Windsor* generally take effect when other changes become effective under the plan. However, for *Windsor*-related elections made between June 26 and December 16, 2013, a plan may provide that the change becomes effective no later than the later of (1) the date that the change would become effective under the plan’s usual procedures, or (2) a reasonable period of time after December 16, 2013.
* *FSA reimbursements.* Participants in health FSAs, DCAPs, or adoption assistance FSAs may be reimbursed for a same-sex spouse’s covered expenses that were incurred on or after the first day of the plan year that includes June 26, 2013, or, if later, the date of marriage. The guidance does not apply to 2012 or earlier years. Same-sex spouses may be treated as covered even if the employee initially elected self-only coverage.
* *Pre-tax health coverage.* Employers receiving notice of the existence of a same-sex marriage before the end of the plan year that includes December 16, 2013, must begin treating amounts paid for spousal coverage as pre-tax salary reductions by the date that a change in marital status is required to be reflected for federal tax withholding purposes following the filing of IRS Form W-4, or, if later, a reasonable period of time after December 16, 2013. Employee payments for spousal coverage are excluded from the employee’s gross income even if the employer reports the amount as taxable income, and participants may seek a refund of any related federal income and employment taxes on their tax return.
* *DCAP limits.* Same-sex spouses are subject to the DCAP exclusion limits for married couples ($5,000 for married couples filing jointly and $2,500 for married individuals filing separately). If the combined DCAP contributions previously elected by the spouses will exceed the applicable limit for the year, contributions for one or both spouses may be reduced for the rest of the tax year so that the limit will not be exceeded. Calendar-year plans are unlikely to be able to make adjustments so late in the plan year. If adjustments are not made, same-sex couples must treat any reimbursements in excess of the applicable limit as taxable income on their tax returns.
* *Plan amendments.* Cafeteria plans that permit election changes due to changes in legal marital status need not be amended to permit *Windsor*-related election changes. However, if an employer chooses to permit election changes not already provided for in the written plan document, ***the plan must be amended to permit the changes by the end of the first plan year beginning on or after December 16, 2013***. The amendment may be effective retroactively to the first day of the plan year that includes December 16, 2013, so long as the plan operates in accordance with the guidance.

Employers and administrators should quickly communicate relevant information to participants and to those responsible for day-to-day plan operations. For example, this could include informing participants of their ability to submit spousal expenses for health FSA reimbursement, health insurance reimbursement, and making human resources staff aware of any changes affecting Form W-2.

See also Q 56, Q 111 to Q 124, Q 417 to Q 419.

119. Are preventive services required to be included without participant cost for non-grandfathered HSA-eligible HDHPs?

Preventive Services Required Without Participant Cost For Non-Grandfathered HSA-Eligible HDHPs.

IRS Notice 2013-57 states that high-deductible health plans (HDHPs) must cover all preventive services mandated under health care reform without imposing a deductible, and grandfathered HDHPs may elect to do the same. Notice 2013-57 clarifies that, for purposes of the HDHP/HSA rules, preventive care not subject to deductibles may include all preventive services and benefits previously defined by the IRS as well as those required under the PPACA and will not jeopardize the HDHP’s health savings account (HSA) qualified status.

For HSA contributions to be tax favored, the employee must be covered under an HSA-qualifying HDHP and generally may not have other health coverage, although there are exceptions, such as vision, dental, and long-term care coverage. For 2013 and 2014, annual deductibles in HSA-eligible HDHPs must be at least $1,250 for self-only coverage ($1,300 for 2015) or $2,500 for family coverage ($2,600 in 2015), but now first-dollar and low-deductible coverage is allowed for preventive care.

The IRS also considers some drugs and medications as excepted preventive care, and health care reform added others. IRS Notice 2004-23 lists the types of preventive care that need not be subject to the high deductible. Its non-exclusive list of safe-harbor preventive care services includes things not intended to treat an existing illness, injury or condition:

* Periodic health evaluations, including tests and diagnostic procedures ordered in conjunction with a routine exam, such as an annual physical.
* Routine prenatal and well-child care.
* Child and adult immunizations.
* Tobacco-cessation programs, including prescription drugs.
* Obesity weight-loss programs, including prescription drugs.
* Screening services, such as for cancer, heart and vascular diseases, infectious diseases, mental health conditions and substance abuse, metabolic/nutritional/endocrine conditions, musculoskeletal disorders, obstetric/gynecological conditions, pediatric conditions, and vision and hearing disorders.
* The “All About HSAs” document on the Health Savings Account section of the IRS Web site (www.treas.gov/offices/public-affairs/hsa/) states that certain drugs and medications can be considered preventive care, such as drugs taken by a person who has developed risk factors for a disease that has not yet manifested itself, or to prevent reoccurrence of a disease. The example provided is cholesterol-lowering medication for individuals with high cholesterol.

All non-grandfathered group health plans, including HDHPs, must provide in-network coverage for mandated PPACA preventive services without participant cost sharing, namely:

* Evidence-based items or services that are rated “A” or “B” by the U.S. Preventive Services Task Force
* Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
* For infants, children and adolescents, evidence-informed preventive care and screenings in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)
* For women, preventive care and screenings provided in HRSA’s Women’s Preventive Services.

120. Are third-party payors permitted to make premium payments to health insurance issuers for Qualified Health Plans on behalf of enrolled individuals?

The Department of Health and Human Services (HHS) has broad authority to regulate the Federal and State Marketplaces (e.g., section 1321(a) of the Affordable Care Act). It has been suggested that hospitals, other healthcare providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces. HHS has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel playing field in the Marketplaces. HHS discourages this practice and encourages issuers to reject such third party payments. HHS intends to monitor this practice and to take action by issuing guidance if warranted.

121. Can 2013 fiscal year cafeteria plan elections to purchase health insurance be changed midyear to purchase insurance on an exchange or in the employer-offered plan for plan years beginning in 2013?

Yes, if the plan is amended, despite the fact that this is not a change in status, which is a normal prerequisite to change a cafeteria plan election.

Employees may want to terminate their election to purchase health insurance through the employer’s cafeteria plan and go to the exchange if they are eligible for health insurance exchange tax credits. Other employees may want to elect to purchase health insurance from the employer plan effective January 1, 2014, to avoid the individual mandate penalty. If the cafeteria plan year is a fiscal year, employees wanting exchange insurance on January 1, 2014, would have to terminate or change their elections midyear. However, under current cafeteria plan regulations, these two elections are not a change in status allowing an election change midyear. The proposed regulations allow an applicable large employer with a fiscal year cafeteria plan, at its election, to amend the plan any time during the year on a retroactive basis (by December 31, 2014, retroactive to beginning of 2013 plan year) to permit either or both of the following changes in salary reduction elections:[[38]](#footnote-39)

(1) An employee who elected to salary reduce through the fiscal year cafeteria plan for accident and health plan coverage beginning in 2013 is allowed to prospectively revoke or change his or her election with respect to the accident and health plan once, during that plan year, without regard to whether the employee experienced a change in status event described in Reg. section 1.125-4; and

(2) An employee who failed to make a salary reduction election through his or her employer's fiscal year cafeteria plan beginning in 2013 for accident and health plan coverage before the deadline in proposed section 1.125-2 is allowed to make a prospective salary reduction election for accident and health coverage on or after the first day of the 2013 plan year of the cafeteria plan without regard to whether the employee experienced a change in status event as described in Reg. section 1.125-4.

Some provisions of the transition relief refer to “applicable large employer members” (i.e., employers that are subject to healthcare reform’s employer mandate), raising questions as to whether the relief is available for all non-calendar-year cafeteria plans or only those that are sponsored by applicable large employer members.

122. How can employers use a state healthcare insurance exchange (marketplace) and other rules to their advantage?

The state healthcare exchanges (also called Marketplaces) were open for business October 1, 2013. There are positive planning opportunities for businesses buying health insurance for employees on these state exchanges. Remember, the healthcare reform law states that every individual must have health insurance coverage or pay a penalty (although there are some exceptions for those with low income, members of Indian tribes, incarcerated, etc.).

Employers with fifty or more full-time and full-time equivalent employees will pay penalties if they do not offer health plans that provide “minimum value” for all ten “essential health benefits” to at least 95 percent of their employees or the coverage is not affordable for the employee, and one or more employees purchase health insurance on an exchange and obtains a subsidy. While the employer mandate penalties imposed upon employers have been delayed until 2015, planning opportunities for 2014 still exist.

Dropping Employer Provided Insurance and Giving Raises. Proponents of healthcare reform state that exchange purchased health insurance coverage will be available for many, especially those with lower incomes at a very low monthly premium after tax credits are applied. The net cost of health insurance purchased on an exchange could be dramatically lower than what is otherwise available for lower income individuals after the subsidies are factored in.

Thus, an employer should look at the aggregate amount the employer pays for health-related coverage and see if it is more cost effective to stop providing insurance coverage and have all of its employees, including management, obtain coverage through the exchange. If an employer has thirty or fewer full-time employees, it will not pay any employer mandate penalty regardless of how the employer handles its health insurance program or if it has none. On the other hand, if an employer’s competitors provide good healthcare coverage, it may be difficult for the employer to retain and attract new employees unless it can show that, with the level of its pay scale and the net cost of health insurance bought by an employee on the exchange, the employee comes out ahead financially.

Thus, if an employer terminates coverage but provides a pay increase, it is possible that the lower income employee (generally under 250 percent of federal poverty income) and the employer could both come out ahead due to the employer’s savings in what it was paying for health benefits and the employee’s increased pay, net after income taxes and subsidized health insurance.

Not Providing Spousal Coverage. The employer mandate penalty is triggered for applicable large employers if the employer does not make an offer of qualifying health coverage to at least 95 percent of its employees and dependents. For this purpose, spouses are not dependents. Thus, some employers are excluding spousal coverage from their health plans. If an employer has high insurance rates because of health liabilities associated with employees’ spouses and terminates spousal coverage, the spouses can obtain insurance coverage through the Exchange in 2014 and thereafter regardless of any preexisting conditions. The employer may be better off giving its employee a bonus that he or she can use to pay for spousal coverage through the Exchange than paying the cost to provide insurance coverage for that spouse.

Providing Employee Health Benefits Not Costing Employee More than 9.5 Percent of Any Employee’s Income. If employer coverage provides minimum value, is affordable, and is offered to at least 95 percent of employees and dependents, the employer, even if an “applicable large employer,” will not face an employer mandate penalty. Affordability is determined by whether the coverage offered to the employee (but not the dependents) costs an employee more than 9.5 percent of his or her annual household income. Because employers may not know employees’ household incomes, three affordability safe harbors may be used.[[39]](#footnote-40)

Thus, an employer can provide enough of the payment toward lower income employees’ insurance so that no employee’s coverage costs more than 9.5 percent of the employee’s pay. An employer can pay a larger amount of a lower paid worker’s health benefits than of a higher paid employee. The employer can charge as much as it wants for dependent coverage (or work with the insurer to do so), as that is not counted in the affordability determination. Remember, it is unaffordable coverage for the employee that can trigger the employer mandate penalty if the employee purchases coverage on an Exchange and obtains a subsidy.

Conclusion. Financial analysis of health benefits is critical for a successful business. Be careful, however, because changing or eliminating health benefits could create employee recruitment and retention issues more significant than the savings.

123. What is limited wrap-around healthcare coverage and how can it be used by employers with at least some employees purchasing subsidized exchange health insurance?

Limited Wraparound Coverage is a new concept effective for plan years beginning in 2015 in regulations[[40]](#footnote-41) from the Departments of the Treasury, Labor, and Health and Human Services (the “Departments”). The Departments propose amending the excepted benefit regulations under the Employer Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code, and the Public Health Service Act (PHSA). Excepted benefits are generally exempt from the market reforms added to these laws by the Patient Protection and Affordable Care Act (PPACA or ACA).

Wraparound coverage is coverage that is an excepted benefit and used when at least some of an employer’s employees are purchasing subsidized exchange health insurance. For an applicable large employer subject to the employer mandate, it will be paying an employer mandate penalty due to employees receiving subsidized coverage on an exchange. In addition, the employer would be paying for the cost of the coverage in the wrap around plan.

These regulations assume that employer-sponsored major medical plans are better than any plan an individual can purchase through an exchange (marketplace). The regulations then assume that some employees will not be able to afford the employer-sponsored plan and will waive the coverage and instead purchase exchange coverage. The employer could then offer wraparound coverage to those employees who purchase exchange coverage comparable to the employer-sponsored plan, taking into account the exchange coverage. The wraparound coverage, subject to certain requirements, is an excepted benefit and thus not subject to the healthcare reform insurance market reform requirements. Thus, an employee enrolled in this limited wraparound coverage would not be disqualified from eligibility for premium tax credits or cost sharing subsidies through the exchange.

In order for wraparound coverage to be an excepted benefit, it must meet seven conditions:

* It can be combined only with individual coverage purchased in the individual market that is not solely excepted benefits.
* It must provide benefits beyond the essential health benefits (EHBs) provided by the individual plan or reimburse the cost of care from out-of-network providers, or both. The wraparound coverage cannot merely provide benefits pursuant to a coordination-of-benefits provision (i.e., just pay for benefits when the individual plan does not cover all or part of an expense).
* The employer’s “primary plan” must offer group coverage that meets minimum value. The primary plan must be affordable for a majority of the eligible employees. Only employees eligible for the primary plan are eligible for the wraparound plan.
* Total cost of coverage (employer and employee cost) under the wraparound must not exceed 15 percent of the cost of coverage under the primary plan.
* The wraparound coverage must not discriminate as to eligibility, benefits, or premiums based on a health factor; it must not contain any preexisting condition exclusions; and neither the wraparound coverage nor the primary coverage can discriminate in favor of highly compensated individuals. These limits prevent employers from using wraparound coverage to send “excessive numbers” of low wage workers to the exchange or to shift employees with high medical costs to the exchange.
* The wraparound coverage cannot replace group coverage for employers that drop coverage altogether or offer coverage that is not of minimum value (i.e., a skinny plan).
* The wraparound coverage cannot be structured so that low-income workers receive fewer primary benefits than high-income workers. Furthermore, enrolling an employee in limited wraparound coverage does not satisfy the large employer’s obligation to offer minimum essential coverage (MEC) under 4980H that is affordable.

A large employer sponsoring limited wraparound coverage will be paying for that coverage and the tax penalty associated with the employee for whom the primary plan was unaffordable. The preamble to these regulations states that “[s]ome group health plan sponsors have asked whether wraparound coverage could be provided for employees for whom the employer premium is unaffordable and who obtain coverage through [the exchange].” The Departments claim that the availability of limited wraparound coverage “promot[es] equity in coverage” by allowing a plan sponsor “to maintain a comparable level of benefits for all potential enrollees.”

1. . PHSA §2711(a)(1). [↑](#footnote-ref-1)
2. . PHSA §2711(b). [↑](#footnote-ref-2)
3. . ERISA Sec. 733(a)(1); PHSA §2791(a)(1). Under ERISA, group health plans are welfare benefit plans. [↑](#footnote-ref-3)
4. . IRC Sec. 9832(a), incorporating by reference IRC Sec. 5000(b)(1). See also Treas. Reg. §54.9831-1(a)(1) (providing a definition of “group health plan ” that mirrors the statute's definition [↑](#footnote-ref-4)
5. . Rev. Rul. 2002-41; IRS Notice 2002-45. [↑](#footnote-ref-5)
6. . Preamble to TD 9491, 6/22/2010. [↑](#footnote-ref-6)
7. . PHSA section 2719(d)(6) provides “employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002 (5)], except that such term shall include only employers of two or more employees. PHSA section 2719(d)(5) provides that “employee” has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002 (6)]. Additionally, 45 CFR 155.20 applies the controlled group and affiliated service group rules to these requirements. [↑](#footnote-ref-7)
8. . 29 CFR §2510.3-3(b), (c) (1997). To trigger ERISA the program must cover a common law employee who is not an owner's spouse. [↑](#footnote-ref-8)
9. . Id. This rule applies even if the shareholder or spouse is also a common law employee of the corporation. It does not extend to cases where the corporation is closely held but not wholly owned by an individual or a married couple. [↑](#footnote-ref-9)
10. . To be excepted benefits, limited-scope dental or vision benefits must be provided either under a separate policy, certificate, or contract of insurance, a condition generally not met by an HRA or must satisfy the conditions necessary for the benefits to be considered “not an integral part” of the employer's other group health plan(s). [↑](#footnote-ref-10)
11. . Prop. Treas. Reg. §54.9831-1(c)(3)(ii); Prop. DOL Reg. §2590.732(c)(3)(ii); Prop. HHS Reg. §146.145(b)(3)(ii); . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537, 34539 (June 17, 2010) (confirming that the exceptions in the Code and ERISA still exist, and announcing an HHS non-enforcement policy with respect to the PHSA provisions); FAQs About the Affordable Care Act Implementation Part II, Q/A-6. [↑](#footnote-ref-11)
12. . Preamble to Interim Final Rules Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections Under PPACA, 75 Fed. Reg. 37188, 37190 (June 28, 2010). [↑](#footnote-ref-12)
13. . Department of Labor Technical Release 2013-03 and Internal Revenue Service Notice 2013-54. [↑](#footnote-ref-13)
14. . See FAQs About the Affordable Care Act Implementation Part XI, Q/A-3 [↑](#footnote-ref-14)
15. . Department of Labor Technical Release 2013-03 and Internal Revenue Service Notice 2013-54. [↑](#footnote-ref-15)
16. . IRC Sec. 213(d). [↑](#footnote-ref-16)
17. . DOL Field Assistance Bulletins 2004-1 and 2006-02. however, too much employer control over AN HSA could make the HSA subject to ERISA. Id. [↑](#footnote-ref-17)
18. . 69 Fed. Reg. 78719, 78734 (December 30, 2004). [↑](#footnote-ref-18)
19. . Treas. Reg. §54.9831-1(c)(3)(v); DOL Reg. §2590.732(c)(3)(v); HHS Reg. §146.145(c)(3)(v). [↑](#footnote-ref-19)
20. . Treas. Reg. §54.9831-1(c)(3)(v)(B); DOL Reg. §2590.732(c)(3)(v)(B); HHS Reg. §146.145(c)(3)(v)(B). [↑](#footnote-ref-20)
21. . Other examples of health FSA funding that meet the maximum benefit condition are:

    • Any one-for-one employer match (employer $600, employee $600).

    • Any employer contribution of $500 or less (employer $500, employee $200). [↑](#footnote-ref-21)
22. . Treas. Reg. §54.9831-1(c)(3)(v)(A); DOL Reg. §2590.732(c)(3)(v)(A); HHS Reg. §146.145(c)(3)(v)(A). [↑](#footnote-ref-22)
23. . Treas. Reg. §54.9815-2711T(a)(2)(ii); DOL Reg. §2590.715-2711(a)(2)(ii); HHS Reg. §147.126(a)(2)(ii). IRC Sec. 106(c)(2) defines the term “flexible spending arrangement” as a benefit program providing coverage under two conditions, one of which is that “the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.” [↑](#footnote-ref-23)
24. . 2007 Prop. Reg. §1.125-5(k)(2). [↑](#footnote-ref-24)
25. . IRS Notice 2013-54, Q&A-7 states: "If an employer provides a health FSA that does not qualify as excepted benefits, the health FSA generally is subject to the market reforms, including the preventive services requirements. Because a health FSA that is not excepted benefits is not integrated with a group health plan, it will fail to meet the preventive services requirements." Q&A-7 says, in effect, that a health FSA that is not an excepted benefit cannot meet the preventive care mandate because the FSA is not integrated with a group health plan. [↑](#footnote-ref-25)
26. . PPACA §1515; IRC Sec. 125(f)(3) [↑](#footnote-ref-26)
27. . Employer Health Care Arrangements at http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements. [↑](#footnote-ref-27)
28. . “Taking a Chance on a Health Insurance Strategy the I.R.S. May Not Approve” at http://www.nytimes.com/2014/06/05/business/smallbusiness/taking-a-chance-on-a-health-insurance-strategy-the-irs-may-not-approve.html?emc=edit\_sb\_20140604&nl=business&nlid=4896825&\_r=0 [↑](#footnote-ref-28)
29. . Employer Health Care Arrangements, Q&A 1 at http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements. [↑](#footnote-ref-29)
30. . PHSA §2711. [↑](#footnote-ref-30)
31. . PHSA §2713. [↑](#footnote-ref-31)
32. . IRC Sec. 4980D(b)(1). [↑](#footnote-ref-32)
33. . IRC Sec. 4980D(c)(3(A). [↑](#footnote-ref-33)
34. Revenue Procedure 2014-30, IRB 2014-20. [↑](#footnote-ref-34)
35. Revenue Procedure 2014-30, IRB 2014-20. [↑](#footnote-ref-36)
36. . If an employer offers a Medicare beneficiary an incentive, financial or otherwise, not to enroll in the plan, the group health plan is subject to a civil money penalty of up to $5,000 for each violation. In addition, an excise tax could be applied that would equal 25 percent of the plan's expenses incurred during the calendar year. 42 USC §1395y (b)(1)(A)(1). [↑](#footnote-ref-37)
37. . 42 USC §1395y (b)(1)(A)(1). [↑](#footnote-ref-38)
38. . Preamble to Proposed Rules on Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 217, 237 (January 2, 2013). [↑](#footnote-ref-39)
39. . Form W-2: An employee’s monthly contribution for self-only coverage is affordable if it does not exceed 9.5 percent of their W-2 wages for that calendar year.

    Rate of pay: An employee’s monthly contribution for self-only coverage is affordable if it is no more than 9.5 percent of their monthly wages (hourly rate of pay × 130 hours, or, for salaried employees, their monthly salary figure).

    Federal Poverty Line (FPL): An employee’s monthly contribution for self-only coverage is affordable if it does not exceed 9.5 percent of the FPL for a single individual. [↑](#footnote-ref-40)
40. . Prop. Treas. Reg. §54.9831–1(c)(3)(i), DOL Prop. Reg. §2590.732(c)(3)(i), HHS Prop. Reg. §146.14(c)(3)(i), 78 Fed. Reg., No. 247 at p. 77632 – 77642 (Dec. 24, 2013). [↑](#footnote-ref-41)