

REFORM UPDATE

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NEW GUIDANCE ISSUED FAQ ON EXCEPTED BENEFITS AND PREMIUM PAYMENT PLANS

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Several government departments recently released guidance to address two issues related to the Affordable Care Act:

- Frequently Asked Questions (FAQ) Part XXIII, regarding excepted benefits
- IRS Notice 2015-17, regarding employer payment plans

This *Reform Update* will summarize the recent guidance.

FAQ XXIII - EXCEPTED BENEFITS

The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) prepare FAQs in response to stakeholder questions regarding the rules of the Affordable Care Act (ACA). This twenty-third FAQ addresses excepted benefits.

Excepted benefits are not required to comply with a number of regulations. In general, they are exempt from market reform and other requirements of the ACA. These include the rules prohibiting annual and lifetime dollar limits on essential health benefits, the 90-day maximum waiting period for benefits eligibility, and the requirement to cover certain preventive care services with no cost-sharing. Excepted benefits are also exempt from the ACA's transitional reinsurance program and the Patient-Centered Outcomes Research Institute (PCORI) fees.

There are currently five categories of excepted benefits:

1. **Non-health related benefits.** These plans are generally not considered medical benefits. They include automobile insurance, liability insurance, workers' compensation and accidental death and dismemberment coverage.
2. **Limited-scope benefits.** This is medical coverage considered limited in scope, such as dental and vision plans. It also includes benefits for long-term care, nursing home care, home health care and community-based care. In addition, medical flexible spending accounts that meet certain requirements fall into the limited-scope category.

3. **“Non-coordinated” benefits.** This includes coverage for a specified disease or illness, cancer-only policies, hospital indemnity, and other fixed indemnity insurance that meet certain requirements.
4. **Supplemental benefits.** To be considered excepted, these types of plans must meet a number of requirements (details noted below).
5. **Wraparound coverage.** These plans were recently deemed excepted, and must meet the following requirements:
 - a) Coverage can wrap around only certain plans provided through the individual market.
 - b) The limited wraparound coverage must be designed to provide benefits beyond those offered by the individual health insurance plan.
 - c) The coverage cannot be an integral part of the group health plan.
 - d) The wraparound coverage must be limited in cost. The total cost of coverage must not exceed 15 percent of the cost of the primary coverage offered to employees who are eligible for the wraparound plan.
 - e) The wraparound coverage must not differentiate among individuals in terms of eligibility, benefits or premiums based on any health factor of an individual or dependent.

Other requirements may apply in addition to those noted above.

The FAQ addresses the fourth type of excepted benefits, supplemental benefits. To be considered excepted, supplemental benefits must meet the following four requirements:

1. The policy, certificate or contract of insurance must be issued by an entity that does not provide primary coverage under the plan.
2. The policy must be specifically designed to fill the gaps in primary coverage, such as coinsurance or deductibles.
3. The cost of supplemental coverage must not exceed 15 percent of the cost of the primary coverage.
4. Supplemental coverage sold in the group market must not differentiate among individuals in terms of eligibility, benefits or premiums based on a health factor of an individual or their dependents.

The Departments have become aware of insurance carriers selling products referred to as an “excepted benefit” that do not actually meet the necessary requirements. In particular, those plans provide a single benefit, not designed to fill the gaps in primary coverage.

The particular question addressed by the FAQ is: Can health insurance coverage that supplements group health plan coverage by providing additional categories of benefits be considered supplemental excepted benefits?

It depends on the situation. The Departments have provided an enforcement safe harbor for plans that are designed to fill gaps in the primary coverage. The Departments will review plans based on the requirements above to determine if a plan offers “similar supplemental coverage” and can therefore be an excepted benefit. The Departments also intend to propose regulations clarifying the circumstances under which supplemental insurance products that do not fill in cost-sharing under the primary plan may be considered designed to fill gaps in primary coverage. This guidance will allow additional categories of benefits to be covered by a supplemental plan. However, if any benefit provided by the coverage is considered an essential health benefit (EHB) in the state where it is marketed, then the coverage **would not** be considered supplemental coverage that qualifies as an excepted benefit.

Until the proposed regulations are issued, the Departments will take a non-enforcement stance as long as certain conditions are met. The Departments will not initiate enforcement action against an insurance carrier for coverage that does not comply with all the ACA requirements if the plan:

1. Provides coverage for additional categories of benefits that are not considered EHBs in the state where the plan is marketed.
2. Complies with all the existing guidance to be considered a “similar supplemental coverage.” The plan may still satisfy the requirement to fill gaps in the primary coverage, even if the plan does not cover cost-sharing, if the plan offers additional benefits that are not considered EHBs.
3. Has been filed with the state and includes the state-approved language.

The Departments will issue additional guidance in the future to address supplemental plans that may not meet the requirements to be considered excepted benefits.

IRS NOTICE 2015-17 – PREMIUM PAYMENT PLANS

This Notice provides more details on the IRS’ position regarding premium payment plans. The general IRS position is that plans set up to reimburse premium payments for active employees’ individual health insurance coverage on a pre-tax basis violate the ACA’s requirements related to the annual dollar maximums and the preventive care requirements. The logic is that these types of plans are group health plans that cannot be integrated with other programs to meet the requirements of the ACA. The IRS has communicated through various notices and Q & As that there will be severe excise tax consequences if an employer violates these rules.

The latest notice provides a number of exceptions in which employers may be able to sponsor a premium payment plan without violating the ACA:

- **Temporary Transition Relief for Non-ALEs.** The IRS will not impose excise taxes, otherwise assessable under Code § 4980H (related to health plan requirements), for payment plans sponsored by employers that are **not** Applicable Large Employers (ALEs). An ALE is an employer with 50 or more full-time and full-time equivalent employees (FTEs) on business days during the preceding calendar year. The premium payment plan must have been maintained during 2014 or for the first six months of 2015 (i.e., through June 30, 2015) for non-ALE employers. Violations of the health plan requirements of the

ACA are required to be self-reported on Form 8928. Employers eligible for this transitional relief are not required to report such violations. The temporary transition relief does not apply to stand-alone health reimbursement arrangements (HRAs) or any other arrangement that reimburses any expenses other than insurance premiums.

- **Relief Pending Guidance for Certain S Corporation Arrangements.** The Notice also addresses two-percent shareholder-employee healthcare arrangements. This type of plan is sponsored by a subchapter S corporation, and pays for or reimburses premiums for individual health insurance coverage for a two-percent shareholder. A two-percent shareholder means an employee of a subchapter S corporation who owns more than two percent of the corporation's stock. These plans will only pay or reimburse health insurance premiums where the payment or reimbursement is included in income and the premiums are deductible by the two-percent shareholder-employee under Code § 162(l). Employers that sponsor these plans for their two-percent shareholders are not required to self-report these violations on Form 8928. This relief does not apply to employees who are not two-percent shareholders. The Notice also clarifies that a plan covering only one individual as an active employee—even if it covers other employees as that employee's dependents—is generally not a group health plan subject to the annual limit and preventive services mandates. It is important to note that this Notice does not mention partnerships. Health coverage provided to partners in a partnership is handled in the same manner as coverage provided to two-percent shareholders of a subchapter S corporations.
- **Medicare Premium Reimbursement Arrangements.** Many employers cannot offer reimbursement arrangements for active employees' Medicare premiums because it would violate the Medicare Secondary Payer (MSP) rules. However, small employers, with fewer than 20 employees, are exempt from the MSP rules.

For purposes of complying with the annual dollar limit and preventive services mandates, this Notice allows an employer to establish a plan to reimburse Medicare Part B or Part D premiums. If the following requirements are met, the plan will be considered integrated with another group health plan offered by the employer:

- The employer offers a group health plan (other than the premium reimbursement arrangement) to the employee that does not consist solely of excepted benefits, and offers coverage providing minimum value.
- The employee participating in the premium reimbursement plan must be enrolled in Medicare Parts A and B.
- Premium reimbursement is available only to employees who are enrolled in Medicare Part A and Part B or Part D.
- Reimbursement is limited to Medicare Part B or Part D premiums and premiums for excepted benefits, including Medigap premiums.

Please be aware that this relief does not apply to retiree-only plans. Retiree-only plans are not subject to the annual dollar limits or preventive care requirements.

- **TRICARE-Related HRAs.** The Notice also allows employers to establish a health reimbursement arrangement (HRA) that pays or reimburses medical expenses for employees covered by TRICARE. If the following requirements are met, the plan will be considered integrated with another employer-sponsored group health plan for purposes of complying with the annual dollar limit and preventive services mandates:
 - 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.
 - The HRA is available only to employees who are enrolled in TRICARE.
 - The employee participating in the HRA is actually enrolled in TRICARE.
 - Reimbursement is limited to cost-sharing and excepted benefits, including the TRICARE supplemental premiums.

The requirements regarding TRICARE are similar to those that apply to Medicare under the MSP rules. These TRICARE-related HRAs may only be allowed for small employers.

- **Increasing Employees' Taxable Compensation.** An employer may increase an employee's taxable compensation, **not conditioned on the purchase of health coverage**, without creating an employer payment plan. In this situation, the tax advantage of employer-sponsored health coverage is not available.
- **After-Tax Employer Payment Plans Are Subject to Excise Tax.** The Notice restates the IRS' position that an employer's *payment or reimbursement* of an employee's individual health insurance premium **is a group health plan** subject to the ACA's market reforms. This applies even if the payments or reimbursements are made on an after-tax basis.

The DOL and HHS concur with the IRS on the provisions of this Notice. These Departments indicated that additional clarifications on other aspects of employer payment plans and HRAs should be expected in the near future.

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