Guidance on Employer Payment Plans Questions Continued Use of Certain Opt-Out Credits

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Recent guidance from the Departments of Treasury, Labor, and Health and Human Services (the Departments) calls into question the continued viability of opt-out credits that an employer offers to employees, where the employee chooses not to enroll in the employer's medical plan and instead receives a cash payment contingent on enrolling in coverage in the individual market. Opt-out credits may adversely impact an employer's affordability calculation for purposes of complying with the employer mandate to offer affordable, minimum value coverage. Employers need to review plan designs for potential issues if the employer offers employees a cash payment in lieu of coverage under its medical plan.

In Notice 2015-17, the Internal Revenue Service (IRS) reiterated previous guidance[1] on an employer payment plan, which is a health plan that either reimburses employees for the premium expenses incurred for an individual health insurance policy or directly pays a premium for an individual health insurance policy coverage on behalf of the employee. Under prior guidance, the IRS has stated that an employer payment plan fails to comply with the group market reforms under the Affordable Care Act. Notice 2015-17 clarifies that an employer payment plan includes any reimbursements or payments made to an employee based on substantiated expenses for premiums under an individual market policy, regardless of whether the reimbursement is made on a pretax or after-tax basis. In contrast, if an employer simply provides an employee with the payment of additional compensation that is not conditioned on the purchase of health insurance coverage, that arrangement is not an employer payment plan and will not be subject to the group market reforms under the Affordable Care Act for group health plans.

Therefore, under this guidance, a plan that provides for an opt-out credit (regardless of whether it's pretax or after-tax) that conditions the receipt of the credit on the individual purchasing individual market coverage is an employer payment plan and does not meet the group market reforms under the Affordable Care Act. A group health plan that does not comply with the group market reform requirements is subject to a penalty of $100/day ($36,500 per year) per impacted individual. Limited transition relief applies to small employers and S-Corporation healthcare arrangements for 2% shareholders.

Notice 2015-17 also clarifies that an employer payment plan includes an arrangement where the employer offers to reimburse Medicare premiums for active employees. This type of arrangement, which is subject to the group market reforms, cannot be integrated with Medicare coverage to satisfy the group market reforms, since Medicare coverage is not a group health plan. However, such an arrangement can be integrated with another group health plan offered by the employer to satisfy these requirements if the following criteria are met:

[1] There have been four pieces of guidance issued on this topic: 1) FAQs About Affordable Care Act Implementation (Part XI) issued on January 24, 2013 by the Departments of Labor (DOL) and Health and Human Services; 2) IRS Notice 2013-54 and DOL Technical Release 2013-03 issued on September 13, 2014; 3) IRS FAQ on Employer Healthcare Arrangements; and 4) FAQs About Affordable Care Act Implementation (Part XXII), issued on November 6, 2014 by the DOL.

1. The employer offers a group health plan (other than the employer payment plan) to the employee that does not consist of only excepted benefits and that offers minimum value coverage;
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.

Employers who have these types of arrangements should also make sure they are complying with the Medicare Secondary Payer rules. If the employer's arrangement is a retiree-only plan on the first day of the plan year (i.e., it has fewer than two participants who are current employees), then it is not subject to the group market reforms and integration is not required. Similar rules apply with respect to a plan that reimburses (or pays directly) some or all of the medical expenses for employees covered by TRICARE (i.e., a TRICARE related HRA).

Affordability and Opt-Out Credits

The IRS has not released guidance addressing the treatment of opt-out credits when calculating affordability under the employer mandate. However, IRS guidance on the treatment of opt-out credits and other payments for purposes of determining affordability under the individual mandate suggests that a similar approach might apply to the employer mandate.

For purposes of determining affordability under the individual mandate, the IRS has stated that the employee's required contribution is reduced by any amount of contributions made by the employer, as long as the employee cannot elect to receive the employer contribution as a taxable benefit (such as cash). Therefore, employer contributions that can be taken as cash, such as opt-out credits, must be counted as employee contributions for affordability purposes under the individual mandate. For example, a plan that requires a $2,000 employee contribution for self-only coverage but offers a $500 opt-out credit will be considered to require a $2,500 contribution for self-only coverage ($2,000 plus the $500 that the employee foregoes by enrolling). It seems likely that this same treatment would apply for purposes of determining affordability under the employer mandate. This means that the employee's contribution would include both the amount actually paid for the coverage and any amount that the employee foregoes in cash.

Additional guidance from the Departments provides for a similar approach. In a frequently asked question (FAQ) released on November 6, 2014, the Departments state that providing high risk claimants a choice between enrolling in the health plan or taking cash is discriminatory because the high risk claimant will in effect have to pay more for the coverage than a non-high risk claimant. In that case, if the employee chooses to enroll in the plan, the cost of coverage for the employee includes the actual cost of the coverage *plus* the amount of money the employee foregoes by choosing to enroll in the employer's plan. For example, if the employee's contribution for coverage under the plan is $2,500 and the employee is offered $10,000 in additional compensation if the employee declines the coverage, the effective cost of the coverage is $12,500—the $2,500 required contribution plus the $10,000 that the employee would forego by enrolling in the plan.

While definitive guidance has not been issued, the above guidance suggests that the Departments will apply a similar approach when calculating affordability under the employer mandate. Employers with employer payment plans or opt-out credits should review their plan designs to determine if such designs violate the group market reform requirements or will potentially impact the affordability requirements under the employer mandate.

Resources

Notice 2015-17 is available at: http://www.irs.gov/pub/irs-drop/n-15-17.pdf

Aon Hewitt's Regulatory Guidance Under the Affordable Care Act page, which provides links to Aon Hewitt bulletins on Affordable Care Act guidance and regulations, is available at: http://www.aon.com/human-capital-consulting/thought-leadership/leg_updates/healthcare/index_regulatory_guidance_affordable_care.jsp

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