YOU CANNOT USE SECTION 105 PLANS AND OTHER REIMBURSEMENT ARRANGEMENTS TO PURCHASE AN INDIVIDUAL PLAN ON A TAX-PREFERRED BASIS

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Let's cut to the chase: An employee cannot purchase an insurance policy sold in the individual health insurance market (i.e., an "individual market plan") with non-taxable contributions. Period. Exclamation point. This includes payments from an employer to reimburse the premiums paid by an employee for an individual-market plan under a Section 105 Medical Reimbursement Plan, a Revenue Ruling 61-146 arrangement, or any other arrangement where employer dollars are being used for such reimbursements. This also includes the purchase of an individual-market plan with employee pre-tax contributions made through a Section 125 cafeteria plan.

Why can't an employee use a reimbursement arrangement to purchase an individual market plan with tax-free employer contributions? General answer: Because an arrangement under which an employer reimburses an employee's substantiated premiums for health insurance (e.g., a Section 105 Medical Reimbursement Plan or a Revenue Ruling 61-146 arrangement) would be considered a "group health plan" under the Internal Revenue Code.

How would a Section 105 medical reimbursement plan be considered a group health plan under the Code? Under the Code, a group health plan is defined as "a plan of, or contributed to by, an employer… to provide healthcare (directly or otherwise) to the employees… or their families."[1] Under a Section 105 Medical Reimbursement Plan,[2] an employer reimburses an employee for the premiums the employee paid to purchase coverage under an individual-market plan. In other words, the employer—out of its own general assets—pays for the premiums for the individual-market plan on the employee's behalf. Employer reimbursements, in substance, are employer contributions. As a result, because employer dollars (i.e., employer contributions/reimbursements) are being used to pay for healthcare (i.e., the individual market plan), a Section 105 Medical Reimbursement Plan is by definition a group health plan under the Code. (And calling the arrangement a Section 105 Medical Reimbursement Plan does not save it from being considered a group health plan under the Code.)

How would a Revenue Ruling 61-146 Arrangement be considered a group health plan under the Code? On September 13, 2013, the Department of Treasury issued Notice 2013-54, which set forth specific rules relating to the purchase of an individual-market plan through certain funding arrangements established by an employer.[3] According to Notice 2013-54, a Revenue Ruling 61-146 arrangement[4] would be considered "a group health plan under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy."[5] Thus, Treasury considers a Revenue Ruling 61-146 arrangement a group health plan under the Code.[6]

Why is being considered a group health plan under the Code important? PPACA added section 9815 to the Code, which incorporates by reference the PPACA market reforms originally added to the

Public Health Services Act (PHSA).[7] Code section 9815 applies to a group health plan as defined under the Code, which means an arrangement like a Section 105 Medical Reimbursement Plan and a Revenue Ruling 61-146 arrangement—which, as discussed, are group health plans under the Code—would be subject to the PPACA market reforms.[8]

The PPACA market reforms include, among others, the prohibition against imposing annual limits on the dollar value of the "essential health benefits" (i.e., the annual limit restriction).[9] Failure to comply with this new requirement results in a penalty equal to $100 per day, per violation, payable by the employer adopting this non-compliant arrangement.[10]

How does a Section 105 Medical Reimbursement Plan and a Revenue Ruling 61-146 Arrangement violate the annual limit restriction? According to Notice 2013-54, a Section 105 Medical Reimbursement Plan and a Revenue Ruling 61-146 arrangement—which, as discussed, are group health plans under the Code—will fail to comply with the annual limit restriction because (1) these reimbursement arrangements are considered to impose an annual limit up to the cost of the individual market plan purchased with the arrangement and (2) the arrangements are not "integrated"[11] with another group health plan that otherwise meets this new requirement (i.e., instead, the arrangements are used to purchase an individual market plan with which the arrangement cannot be "integrated").[12]

But if premiums are not essential health benefits, how do Section 105 Medical Reimbursement Plans and Revenue Ruling 61-146 Arrangements violate the law? Many stakeholders in the healthcare industry have argued that because premiums of an individual market plan are not considered essential health benefits,[13] an arrangement that reimburses an employee for health insurance premiums up to a specified allowance does not violate PPACA's annual limit restriction. While this argument has some merit because premiums for health insurance are fundamentally different from the types of medical services that are otherwise considered the essential health benefits, Treasury, Labor and HHS have flatly rejected this argument.

WILL THE FEDERAL GOVERNMENT EVER PERMIT EMPLOYEES TO PURCHASE AN INDIVIDUAL MARKET PLAN ON A TAX-PREFERRED BASIS? ONLY TIME WILL TELL.

Specifically, instead of agreeing with this argument, the federal agencies reiterated and re-affirmed their contrary position in Notice 2013-54 (and related guidance), providing that "an annual limit up to the cost of the individual market plan" purchased through a group health plan still violates the annual limit restriction.[14] Thus, while employers and other stakeholders may find this position to be arbitrary, this position is controlling unless and until the federal agencies issue guidance indicating otherwise. This means that if an employer fails to act in accordance with this position, the employer will be subject to a $100 per day, per violation excise tax.

Can an employee use a Section 125 cafeteria plan to purchase an individual market plan outside the exchange with pre-tax employee contributions? General answer: Although Notice 2013-54 did not explicitly address this question, it appears that employee pre-tax contributions made through a Section 125 cafeteria plan cannot be used to purchase an individual market plan sold outside of the new PPACA Exchange.[15]

Why not? Employees participating in a Section 125 cafeteria plan[16] are permitted to pay the portion of premiums for health insurance coverage not otherwise paid for by their employer on a pre-tax basis through salary reduction.[17] Treasury treats these salary-reduction contributions as employer contributions so they can be excluded from income under Code Section 106 (i.e., so the salary-reduction contributions for health insurance coverage are not taxed for income or FICA taxes).[18] As discussed above, under the Code, a group health plan is defined as "a plan of, or contributed to by, an employer…to provide healthcare (directly or otherwise) to the employees…or their families."[19] Thus, by virtue of employee contributions under a Section 125 cafeteria plan being considered employer contributions, a Section 125 cafeteria plan would be considered a group health plan under the Code.

As also discussed above, as a result of the addition of Code section 9815, a group health plan under the Code is subject to all of the PPACA market reforms, including the requirement to provide certain preventive services with no cost-sharing.[20] Importantly, Notice 2013-54 provides that a reimbursement arrangement—such as a Section 105 Medical Reimbursement Plan or a Revenue Ruling 61-146 arrangement—"does not provide preventive services without cost-sharing in all instances."[21] Similar to these reimbursement arrangements, it would appear that a Section 125 cafeteria plan also fails to "provide preventive services with no cost-sharing in all instances," and, therefore, it would appear that a Section 125 cafeteria plan violates this new requirement.

The only way a Section 125 cafeteria plan could satisfy the no-cost-sharing-for-preventive-services rule is if the cafeteria plan was "integrated" with another group health plan that met this new requirement.[22] But, if a Section 125 cafeteria plan is being used to purchase an individual-market plan, the

cafeteria plan by definition cannot be "integrated" with a group health (and, according to the Notice 2013-54, the cafeteria plan cannot be "integrated" with the underlying individual market plan).[23]

Therefore, it would appear that, in this case, the Section 125 cafeteria plan would fail to provide preventive services without cost-sharing in all instances, thereby violating PPACA.

What type of reimbursement arrangements can be used to purchase an individual market plan? An arrangement that provides reimbursements on an after-tax basis may be used to purchase an individual market plan both inside and outside of the PPACA Exchange.

How? Notice 2013-54 states: "Employers may establish payroll practices of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee without establishing a group health plan, if the standards of the DOL's regulation section 2510.3-1(j) are met."24 This means that employers can still reimburse the premiums paid by an employee for an individual market plan. But these reimbursements must be taxable (i.e., the employee pays income taxes and both the employer and employee pay FICA taxes on the reimbursement amounts). In addition, the employer must walk the fine line of satisfying all of the requirements set forth under the DOL regulation section 2510.3-1(j).

CONCLUSION

Will the federal government ever permit employees to purchase an individual market plan on a tax-preferred basis? Only time will tell. If the politics in Washington, DC, change after the 2016 elections and/or the newly reformed insurance markets stabilize over time, an argument can be made that the federal agencies' current position may change. This author is optimistic that this position could indeed change. However, unless and until there is a change in policy, employers that adopt an arrangement that reimburses the premiums paid by an employee for an individual-market plan with non-taxable contributions will be subject to a penalty equal to $100 per day, per violation. HIU

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1 Section 9832(a) of the Internal Revenue Code, cross-referencing Code section 5000(b)(1).

2 A Section 105 Medical Reimbursement Plan has been characterized as a "self-insured medical expense reimbursement plan" as defined under Code section 105(h)(6). Code section 105(h)—where the definition of a self-insured medical expense reimbursement plan is placed—sets forth rules for prohibiting discrimination in favor of highly paid individuals under a self-insured group health plan. Properly reading the definition of self-insured medical expense reimbursement plan in context, a strong argument can be made that this definition is applicable solely in the context of these non-discrimination rules. This means this definition should not be used for justifying how the tax laws work in other areas, as well as attempting to describe this arrangement as something other than a "group health plan" under the Code.

3 The DOL issued identical guidance in Technical Release 2013-03, and HHS intends to issue guidance to reflect that the Department concurs with Notice 2013-54 and the Technical Release.

4 In 1961, the IRS issued formal guidance in the form of a Revenue Ruling, holding that employer payments made under an arrangement to reimburse the premiums for an individual market plan are excluded from an employee's gross income under Code section 106.

5 Notice 2013-54, Section I; see also, Notice 2013-54, Section II.B.

6 Id. It is important to understand that even if a reimbursement arrangement is not considered a "group health plan" under the ERISA, the reimbursement arrangement will still be considered a "group health plan" under the Code for the reasons discussed in the body of this article. This is because the definition of a "group health plan" under ERISA and the Code are different. So, for example, there may be instances where an arrangement is not considered a "group health plan" for purposes of ERISA, but the arrangement still meets the definition of a "group health plan" under the Code.

7 Section 1563(f) of the Patient Protection and Affordable Care Act.

8 Code Section 9815 was placed in Chapter 100 of the Code, which sets forth rules applicable to "group health plans" as defined under Code Section 9832(a).

9 See section 2711 of the Public Health Services Act. PPACA added PHSA section 2711, requiring insurance carriers (in the case of individual or fully-insured group health insurance coverage) and employers (in the case of a self-insured plan)—for plan years beginning on or after September 23, 2010—to phase out any annual limits imposed on the dollar value of "essential health benefits" over a three-year period. [PHSA section 2711(a)(2)]. For plan years beginning on or after January 1, 2014, no annual limits may be imposed on the dollar value of "essential health benefits" under an individual health insurance policy or a group health plan (fully insured and self-insured). [PHSA section 2711(a)(1)]. On June 28, 2010, HHS, Treasury and Labor (hereinafter referred to as the "federal agencies") issued interim final regulations implementing, among other things, new PHSA section 2711. [See 75 Fed. Reg. 37188 (June 28, 2010)].

10 Code Section 4980D(b)(1).

11 In general, to be considered an "integrated" reimbursement arrangement, an employee receiving any reimbursements must also be (1) enrolled in another group health plan offered by the employee's employer or (2) enrolled in a group health plan offered through the employee's spouse's employer, provided the underlying group health plans satisfy, among other things, the annual limit restrictions.

12 Notice 2013-54, Section III.A.1, Q&A-1. It is important to note that—according to the federal agencies—if a group health plan cannot satisfy the annual limit restriction on its own, the group health plan must be "integrated" with another group health plan that otherwise meets this requirement (as described in footnote 11). In addition, according to Notice 2013-54, a group health plan that is used to purchase an individual market plan cannot be "integrated" with the underlying individual market plan (and it by definition is not "integrated" with another group health plan). Therefore, if the group health plan used to purchase the individual market plan—on its own—cannot satisfy the annual limit restriction, this plan will be found to have violated the annual limit restriction requirement.

13 The "essential health benefits" are a list of specified medical services that must be covered under individual and small group market plan. HHS issued regulations implementing the "essential health benefits" requirement, effectively permitting states to designate an "essential health benefits"-benchmark plan. In most states, the "essential health benefits"-benchmark plan is the most popular health

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