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The Revolution of Employer-Sponsored Health Insurance

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On Oct. 12 President Donald Trump issued an executive order regarding the federal laws governing health care and insurance. The executive order itself does not change the existing rules. Rather, it instructs the applicable federal agencies — the U.S. Departments of Treasury, Labor, and Health and Human Services — to "consider proposing regulations or revising guidance" in accordance with the guidelines in the executive order. Those guidelines relate to three different aspects of health insurance:

1. The order instructs the DOL to consider loosening the requirements for employers to band together and form "association health plans" (within 60 days). These plans are arguably not subject to the Affordable Care Act's individual and small-group requirements if they have at least 50 members.

2. It also instructs the DOL, Treasury and HHS to consider expanding (within 60 days) the availability of short-term, limited duration insurance, which is a type of individual insurance not subject to ACA market reform requirements.

3. Lastly, the order instructs the DOL, Treasury and HHS to consider expanding (within 120 days) access to and availability to health reimbursement arrangements (HRAs), including rules to "allow HRAs to be used in conjunction with nongroup coverage." Presumably, this guidance would also extend to "employer payment plans" (EPPs), a similar arrangement that only reimburses premiums (and not other cost-sharing).

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Any guidance issued in accordance with items one and two above would likely have a relatively small impact on employer-sponsored health insurance (ESI) plans of large employers. But new guidance consistent with item three could fundamentally transform how employers provide ESI — the source of coverage for over 170 million Americans — upending the traditional ESI structure that has been commonplace since ESI's inception during the World War II era. This transformation would occur to the extent employers replace their traditional ESI plans (e.g., health maintenance organizations (HMOs) and preferred provider organizations (PPOs)) with HRAs or EPPs that pay for individual insurance coverage on the ACA exchanges or a private exchange (generally referred to as "stand-alone HRAs").

The key unanswered question, however, is just how many of 170 million or so Americans with traditional ESI will employers send to the individual market?

Before the ACA, Stand-Alone HRAs and EPPs Were Permitted, Albeit Inviable

Stand-alone HRAs and EPPs are not a new concept; rather, they were permitted before the ACA was enacted. Yet employers rarely utilized those plans — in large part, because the lack of individual market protections made stand-alone HRAs and EPPs impractical for many employees. But because the ACA imposes guaranteed issue, community rating and other substantive insurance protections, stand-alone HRAs and EPPs are arguably a viable alternative to traditional ESI plans — and would still provide significant tax benefits to employers and employees.[1]

How HRAs and EPPs Operate

An HRA is an account-based plan that an employer can use to reimburse, tax-free, an employee for out-of-pocket medical expenses and health insurance premiums paid by the employee, the employee's spouse or the employee's eligible dependent children (to the extent the employee did not originally pay those amounts on a pretax basis). Unused HRA amounts may carry over for use by the employee in future years. Similarly, an EPP allows an employer to reimburse an employee tax-free for an insurance premium, but not other medical expenses.

Agency Guidance Currently Prohibits Most Stand-Alone HRAs and EPPs

A number of the ACA's market reform requirements apply to "group health plans." HRAs and (arguably) EPPs are group health plans for this purpose. As such, they must comply with all applicable ACA requirements. Since 2013 the agencies have taken the position that stand-alone HRAs and EPPs (i.e., that are used solely to pay for individual insurance coverage) violate two ACA requirements for group health plans:

1. ***Required Coverage of Preventive Health Services:*** The ACA requires non-grandfathered group health plans to provide certain preventive services (e.g., contraceptives) without imposing any cost-sharing requirements for these services. The agencies have taken the position that because HRAs and EPPs contain reimbursement limits, they violate this requirement.
2. ***Prohibition of Annual and Lifetime Limits on Essential Health Benefits (EHBs):*** The ACA also prohibits group health plans (including grandfathered plans) from imposing annual or lifetime limits on EHBs. The agencies similarly view HRAs and EPPs as violating these requirements because those plans do not provide for unlimited reimbursements of EHBs.[2]

Some have argued that EPPs do not violate these ACA requirements because they only reimburse premiums, which are not a type of EHB. The agencies have expressly rejected that argument.

The penalties for a stand-alone HRA that violates these ACA rules are hefty. The Internal Revenue Code, for example, imposes excise taxes under Section 4980D of up to $100 per day per plan participant.

Narrow Statutory Exemptions Exist for Certain Stand-Alone HRAs and EPPs

There are a few limited exceptions where stand-alone HRAs or EPPs can be used without violating the ACA's market reform rules:

1. ***Plans That Cover No More Than One Current Employee:*** The ACA's market reforms do not apply

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to a group health plan that has fewer than two participants who are current employees on the first day of the plan year (e.g., a retiree-only HRA). Separate stand-alone HRAs and EPPs are generally aggregated for this purpose, so an employer cannot establish separate plans to rely on this exemption.

2. ***Limited-Scope Plans:*** The ACA's market reforms similarly do not apply to HRAs that only reimburse "excepted benefits" (e.g., dental and vision expenses or premiums).

3. ***Qualified Small Employer HRAs:*** Lastly, the ACA does not apply to "Qualified Small Employer Health Reimbursement Arrangements" (QSEHRAs). QSEHRAs are specifically authorized by statute as a result of the 21st Century Cures Act, which was enacted on December 13, 2016. QSEHRAs are only available to an employer that employs fewer than 50 full-time employees (including full-time equivalent employees) in the previous year (determined using the counting method under the ACA's employer mandate rules). QSEHRAs are also subject to a number of other substantive requirements and limitations. For example, the QSEHRA must limit annual reimbursements to $4,950 for employee-only coverage and $10,000 for family coverage.

Will Employers Terminate their Traditional ESI Plans?

When compared to the "hands off" approach of simply paying for employees' individual insurance premiums via a stand-alone HRA or EPP, sponsoring a major medical ESI plan (particularly a self-funded plan) is costlier with regard to administration and legal compliance.[3] But legal and administrative costs aside, not every employer would likely take advantage of the opportunity to replace their current ESI coverage with a stand-alone HRA or EPP. Rather, employers would likely take into account a number of factors, such as:

- ***Collective Bargaining Concerns:*** For employers with unionized populations, many of their collective bargaining agreements may require the employer to offer specific coverage. Replacing that ESI coverage with a stand-alone HRA or EPPs would almost certainly violate those collective bargaining agreements. (Similarly, replacing non-union employees' ESI coverage with stand-alone HRAs or EPPs might cause those employees to considering joining their co-worker's union.)

- ***Size, Nature and Diversity of Workforce:*** Depending on the make-up of the employer's workforce, offering traditional ESI coverage might be a competitive necessity. Around 60 percent of large employers sponsor a self-funded ESI, which allows for greater control over plan design and benefits. If an employer opts to use a stand-alone HRA or EPP, however, employees will be limited to choosing from whichever options are available on the individual market. For example, employers with large populations of highly skilled workers (e.g., tech companies) might find it difficult to attract the necessary talent without a traditional ESI plan.

- ***Stability of the Individual Insurance Market:*** Over the past nine months, state individual insurance markets have become increasingly unstable, with premiums set to increase substantially in a number of states. The Trump administration's announcement last week to eliminate cost-sharing reduction payments to insurers will certainly increase market instability — causing at least a 20-percent premium spike for certain plans in 2018 alone, according to the Congressional Budget Office. Both employers and employees are unlikely to see much value in stand-alone HRAs and EPPs unless there is viable coverage to purchase in the individual market.

According to a recent survey from the benefits consulting firm Mercer, 16 percent of surveyed employers said they would consider using a stand-alone HRA for all eligible employees if it were legal; 8 percent said they would consider it for part-time or some other subset of employees; 21 percent said they might consider it depending on the strength of the individual market; 42 percent said they might consider it, but that their decision depends on whether adequate funding is allowed; and 34 percent said they would not consider using a stand-alone HRA regardless of legality.

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Would Agency Guidance Allowing Stand-Alone HRAs and EPPs Survive a Court Challenge?

A challenge to any guidance implemented by the agencies in accordance with the executive order's instructions seems inevitable—especially with the prospect of employees losing their ESI coverage and being sent to the insurance exchanges with HRAs or EPPs. Such a case would seem to (at least in part) center on the interpretation of (1) the ACA statutes regarding preventive care and annual and lifetime limits; and (2) with regard to EPPs, potentially the statutory definition of "group health plan".

One obstacle for the administration, for example, could include that in 2016 Congress statutorily exempted QSEHRAs from the ACA's market reform rules. Does that legislation effectively validate the agencies' positions that stand-alone HRAs and EPPs otherwise violate the ACA? Or was the legislation simply the product of necessity given that there was a Democratic president at the time? The latter argument is arguably a difficult one to defend because Congress passed the 21st Century Cures Act in December 2016 — after Trump won the election.

Could Employers Use Stand-Alone HRAs and EPPs to Send their Sick Employees to the Exchanges?

When the ACA was passed in 2010, the Obama administration expressed concern that because the ACA required guaranteed issue and community rating in the individual market, employers would "dump" their sicker employees on the exchange. The possibility of stand-alone HRAs and EPPs has renewed those concerns among healthcare economists and policy experts — that is, whether employers could selectively offer stand-alone HRAs and EPPs to their sicker employees, while maintaining traditional ESI for other employees.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically prohibits this approach:

> A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual.[4]

But even with these HIPAA protections, the risk of health-status discrimination is arguably higher when employers have the option of stand-alone HRAs and EPPs. Employers arguably could offer both stand-alone plans and traditional ESI and impose indirect and less transparent restrictions on the ESI plan to entice sicker employees to opt for exchange coverage (e.g., eliminating coverage for certain benefits and reducing the number of specialists in the plan's provider network). And although such restrictions arguably still violate HIPAA when their purpose is to discriminate against sicker workers, it would be up to the executive agencies to detect and police those violations — or for participants to challenge the discriminatory practices in federal court.

Similar discrimination issues could arise for employers that adopt stand-alone HRAs or EPPs to pay for active employees' Medicare Part B or D premiums and expenses — particularly if active employees are given a choice between traditional ESI coverage and more generous HRA or EPP coverage. The Medicare secondary payer (MSP) rules generally prohibit employers from offering Medicare-eligible individuals "financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a GHP that is, or would be, primary to Medicare." The applicable regulation specifically prohibits offering "an alternative to the employer primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare." Stand-alone HRAs or EPPs that are designed to entice Medicare-eligible employees to switch from traditional ESI coverage to Medicare would arguably violate this requirement. One type of problematic arrangement, for example, would be where the employer offers all employees (for optics purposes) a choice between (1) a high-deductible, self-funded ESI plan, or (2) a stand-alone EPP that can only be used to pay for eligible Medicare expenses.[5]

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What Lies Ahead

As stated above, the executive order does not actually change the law. So although it seems likely that the agencies will issue guidance expanding the availability of stand-alone HRAs and EPPs, the specifics of that guidance — and its specific impact — remain elusive. And given that the order instructs to agencies to propose "rules," which are subject to a number of procedural and timing requirements under the Administrative Procedure Act, it is highly unlikely that such agency guidance will be released before the end of this year. But once formal guidance on this topic is issued, it could lead to a new era of ESI — unless the guidance is successfully challenged in court.

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[1] The federal tax exclusion for payments to and benefits under ESI coverage is the largest tax "expenditure" in the United States, which saves about $250 billion in income taxes (employees) and FICA taxes (both employees and employers) annually.

[2] The agencies do not prohibit HRAs and EPPs that are properly "integrated" with ACA-compliant ESI coverage, such as an HMO that does not place annual or lifetime limits on EHBs and meets the ACA's preventive care and other requirements. A number of requirements must be met for the HRA or EPP to be considered integrated for this purpose, but the general premise behind integration is that the HRA and other ESI plan are essentially treated as a single, ACA-compliant plan.

[3] HRAs and EPPs are "minimum essential coverage" for purposes of the ACA's employer mandate rules, so absent contrary guidance, employers that replace their traditional ESI plans with stand-alone HRAs and EPPs can do so without risking exposure to employer mandate penalties.

[4] Treas. Reg. §54.9802-1(b)(1)(i); DOL Reg. §2590.702(b)(1)(i); HHS Reg. §146.121(b)(1)(i).

[5] In theory, a Medicare-reimbursement EPP might be permissible if it were the only ESI plan offered to active employees, but it would be completely impractical for an employer offer such an arrangement as the only ESI available to employees.

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