

# **State Strategies to Revive Defined Contribution Health Plan Options in Response to New Federal Obstacles**

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Peter J. Nelson, J.D.  
Director of Public Policy  
Center of the American Experiment

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**ABSTRACT:** Many employers and their employees would prefer a defined contribution health plan in which the employee receives a fixed, pre-tax cash allowance from the employer to purchase health insurance coverage on the individual market. The arrangement gives employers better control over their health care spending and gives employees choice, ownership and security in a portable health plan they can keep when they leave their job. Despite these benefits, the practice of employers funding individual health coverage has never been widespread due to long-standing legal and practical obstacles. The passage of the Patient Protection and Affordable Care Act (ACA) appeared to clear away the most serious obstacles and, thereby, open the door to more and more employers funding individual health plans through defined contribution arrangements. Yet federal guidance now holds employer arrangements to fund individual market premiums violate ACA insurance market reforms and, therefore, bars these types of defined contribution health plans. There is no sound legal basis to support this holding. It contradicts prior federal court and agency holdings and, moreover, conflicts with provisions in the ACA that show Congress intended to continue allowing employers to fund individual premiums pre-tax. As a result, the Obama administration invites yet another legal challenge to the ACA. Instead of a lawsuit, states can also consider a less confrontational and more collaborative approach to allow employers to fund individual coverage that addresses the federal governments concerns. To revive opportunities for employers to fund individual coverage without violating federal guidance, a state can create a new category of group coverage that merges elements of individual and group coverage.

## INTRODUCTION

Many employers would like to offer their employees a defined contribution health plan in which the employee receives a fixed, pre-tax cash allowance to purchase health insurance coverage on the individual market. The arrangement gives employers better control over their health care spending and gives employees choice, ownership and security in a portable health plan they can keep when they leave their job.<sup>1</sup> A simple pre-tax contribution for individual coverage would be especially attractive to the growing portion of small employers that don't offer coverage. Between 2008 and 2014, the portion of employers with fewer than 50 employees that do not offer health insurance coverage grew from 56.8 percent to 67.8 percent.<sup>2</sup> More broadly, by increasing the number of people shopping for individual coverage, the expansion of these defined contribution health plans increases competition in the individual market, which should drive up quality and drive down costs.<sup>3</sup>

Despite these benefits, the practice of employers funding individual health coverage has never been widespread due to long-standing legal and practical obstacles. The ACA, however, appeared to clear away the most serious obstacles and, thereby, open the door to more and more employers funding individual market coverage through defined contribution health plan arrangements. But federal guidance issued in September 2013 shut this door.

Businesses, according to guidance from the Departments of Treasury and Labor, can no longer help their employees pay individual market health insurance premiums with pre-tax dollars. This possibly ends a practice the IRS has recognized and allowed since 1961. Clarity in this area of the law is rare and, not surprisingly, there remain some questions over whether avenues still exist for employers to fund individual plans pre-tax. After all, the guidance did not officially retract prior IRS regulations. Moreover, the federal tax code remains largely unchanged. Nonetheless, the prevailing legal interpretation concludes the new guidance bans the most straightforward and sensible ways for employers to establish defined contribution health plans to fund individual market premiums.

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<sup>1</sup> Individually-owned insurance was a key element of the Mayo Clinic Health Policy Center's recommendations released in 2007. Their recommendations note how "[i]ndividual ownership would allow health insurance to evolve into a service that gives patients more control and choice." MAYO CLINIC HEALTH POL'Y CENTER, BUILDING UPON THE CORNERSTONES: RECOMMENDATIONS, ACTION STEPS AND STRATEGIES TO ADVANCE HEALTH CARE REFORM (2007), available at <http://www.mayoclinic.org/documents/building-cornerstones-final-pdf/doc-20079626>. See also, Mark V. Pauly and Allison M. Percy, *Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets*, 25 J. OF HEALTH POL., POL'Y AND LAW 1, 9-26 (2000) ("Another advantage of individual insurance is that, in contrast to those with workplace insurance, people with individual insurance need not be concerned with losing or changing their insurance because they change jobs or because their employer redesigns or reduces benefits. When people have their own health insurance, it is almost perfectly portable and highly adaptable to their demands and tastes.")

<sup>2</sup> AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, MEDICAL EXPENDITURE PANEL SURVEY, TABLE II.A.2 (2008), available at [http://meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2008/tiia2.htm](http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiia2.htm); and AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, MEDICAL EXPENDITURE PANEL SURVEY, TABLE II.A.2 (2014), available at [http://meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2014/tiia2.htm](http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2014/tiia2.htm).

<sup>3</sup> Mayo Clinic *supra* note 1 ("Insurers would compete for an individual's business by offering competitive rates and providing access to networks of doctors. If the insurance plan didn't meet expectations, people could change insurers.")

The guidance holds that funding individual market coverage through a group health plan now violates two new health plan requirements in the Affordable Care Act (ACA)—the prohibition against annual limits on the dollar value of benefits and the requirement to provide certain preventive services without any cost sharing. According to the guidance, the requirements are violated because individual market coverage cannot be integrated with a group health plan. Thus, two health plan requirements effectively change the tax treatment of employer contributions to individual coverage, not any change to the tax code.

The main problem undermining this holding is that the two ACA requirements apply to both the individual and group markets equally. Therefore, whether an employer funds individual or group coverage, their employees will ultimately be covered by plans that meet the requirements. The guidance fails to explain why a violation exists only in the context of integrating individual market coverage with a group health plan. Without an explanation and without a change to the tax code, the Obama administration fails to provide convincing legal authority to limit the pre-tax payment of individual market premiums. In doing so without clear authority, the Obama administration invites yet more litigation against the ACA.

This Article evaluates the new bar against employers contributing to individual health insurance coverage in three parts. Part I focuses on the legal obstacles and opportunities to employers funding individual market premiums and how this legal treatment changed from before the ACA passed to the issuance of the federal guidance.

Part II analyzes the legal and policy rationales underlying the new ban on employer-funded individual market premiums. Upon review, this Article concludes the Departments of Treasury and Labor offer no convincing legal basis to support their holding. Understanding the policy rationale helps inform the discussion in Part III on how states can respond.

Part III proposes two possible responses to the present ban on employers funding individual market premiums. One obvious response is a legal challenge, but litigation isn't the only possibility. Though federal regulatory actions generally preempt, or preclude any state response, states retain substantial authority to regulate insurance. In this case, there is an opportunity for states to change how they regulate and structure insurance markets in a way that both aligns with the federal guidance and revives the opportunity for employers to offer tax-advantaged defined contribution health plans to fund individual coverage.

## I. OBSTACLES AND OPPORTUNITIES TO EMPLOYER-FUNDED INDIVIDUAL HEALTH INSURANCE PREMIUMS

Back in 1961, in Rev. Rul. 61-146, the IRS held that individual insurance premiums paid by an employer can be excluded from income under IRS Code Section 106 just like other health care costs.<sup>4</sup> Despite the availability of the tax exclusion, a combination of federal and state laws

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<sup>4</sup> IRS Rev. Rul. 61-146, 1961-2 C.B. 25, available at <http://www.irs.gov/pub/irs-drop/rr-61-146.pdf>. Despite a clear holding that individual insurance premiums are excludable from income in Rev. Rul. 61-146, there has always been legal uncertainty over which arrangements an employer can use to fund individual market premiums. More clarity surfaced in 2002 when the IRS ruled that individual market premiums could be funded through Health

posed substantial obstacles to establishing a defined contribution health plan to fund individual health insurance coverage on a pre-tax basis.<sup>5</sup> The ACA eliminated those obstacles, which appeared to open the door to a substantial expansion of these defined contribution arrangements. However, regulatory guidance issued by the Departments of Treasury and Labor, in effect, now bars employers from funding individual market insurance premiums. This Part explains how opportunities for employers to fund individual market premiums changed from the before the passage of the ACA to the issuance of the guidance.

## A. PRE-ACA OBSTACLES

Most Americans with private health coverage receive group coverage through their employer and, as a result, do not own their health insurance like they own other types of insurance. This is in large measure due to a strong bias for employer-sponsored insurance in the federal tax code. Health care costs paid by employers are excluded from income, providing substantial tax savings. Though employers can, in theory, fund individual health plans and still take advantage of the tax exclusion, federal and state laws regulating employer health plans made this impractical, if not impossible for most employers.

The main legal problem is that when an employer contributes to an individual market premium, the employer's health plan arrangement, in many cases, becomes a group health plan subject to group market regulations under federal law. Prior to the ACA, these federal group market regulations were usually not compatible or aligned with state individual market regulations. For instance, before the ACA took full effect in 2014 most individual market plans priced people, in part, on their health status whereas federal small group market regulations prohibited discrimination on health status. This incompatibility made it very difficult for employers to fund individual market premiums without violating federal group regulations.

Even if federal law clearly allowed employers to contribute to individual market premiums, there remained a huge practical obstacle to doing so. Prior to 2014, insurers in the individual market could deny coverage based on health status in all but six states.<sup>6</sup> Consequently, if an employer offered to pay individual market premiums in a state that allowed coverage denials, some employees would likely be denied coverage in the market. Obviously, this is not an ideal situation. Employers offer health coverage, in part, to maintain a healthy workforce and have a strong interest in making sure *all* of their employees are covered. They also offer health coverage to compete for the best employees and a health package that risks a coverage denial

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Reimbursement Arrangements. IRS Notice 2002-45, 2002-28 I.R.B. 93, available at <http://www.irs.gov/pub/irs-drop/n-02-45.pdf>. And then in 2007, the IRS issued interim final regulations that confirmed section 125 plans can be used to pay individual premiums. IRS REG-142695-05, 2007-39 I.R.B. 681, 697, available at [http://www.irs.gov/irb/2007-39\\_IRB/ar14.html](http://www.irs.gov/irb/2007-39_IRB/ar14.html). Combined, IRS statements on HRAs and section 125 plans confirmed employers had broad flexibility to fund individual coverage with pre-tax contributions.

<sup>5</sup> Note that defined contribution health plans also exist to fund group coverage. Most of the private insurance exchanges in operation and development today connect employees with group coverage. Being group coverage, these arrangements suffer from the same lack of portability and security provided by individually-owned health insurance coverage. Furthermore, choice is often severely constrained under these arrangements.

<sup>6</sup> KAISER FAMILY FOUNDATION, HEALTH INSURANCE MARKET REFORMS: GUARANTEED ISSUE (June 2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8327.pdf>.

would not be competitive. And, of course, there is the basic matter of fairness to employees. Like the legal obstacles, this practical issue only surfaces because the group and individual markets are regulated differently.

## B. THE ACA REMOVES THE MAIN OBSTACLES

Effective January 1, 2014, the ACA largely eliminated the regulatory differences between small group and individual market coverage. Just like small group coverage, individual insurance is now prohibited from discriminating or denying people coverage based on their health status.<sup>7</sup> The small group and individual markets are also subject to the same rules on setting premium rates. Further, the health benefits required to be offered in the individual and small group markets are, in most states, the same.<sup>8</sup> The only substantial regulatory difference between individual and small group coverage—the annual deductible limits for small group coverage—was repealed in 2014.<sup>9</sup> Large groups are not subject to exactly the same requirements, but, to the extent there are differences, large group requirements are less restrictive, which means there is no large group requirement the individual market would fail to satisfy.

By eliminating the regulatory differences between small group and individual market plans, employer funding of individual market plans should no longer violate federal group market regulations.<sup>10</sup> Also, under the new regulations employers will know their employees won't be denied coverage when they offer funding for individual market coverage. In this way, the ACA appears to clear a path to employer funding of individual market premiums with pre-tax dollars in most states.

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<sup>7</sup> PPACA § 1201, 42 U.S.C. § 300gg-4.

<sup>8</sup> The ACA requires individual and small groups to provide coverage for a package of essential health benefits. Most states rely on a benchmark plan based on a state's small group plan, which, consequently, aligns the individual market benefit requirements with the group market. National Conference of State Legislatures, *State Health Insurance Mandates and the ACA Essential Benefits Provisions* (Updated: September 2015), at <http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx>.

<sup>9</sup> Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 213, 128 Stat. 1040, 1047. The ACA recognizes some states may wish to merge their individual and small group insurance markets. If a state chooses to merge markets, federal regulations implementing the small business health options Program (SHOP) exchange cite only two unique requirements of the small group market that must be met for employees to enroll through the SHOP: the annual deductible limits and the metal levels of coverage. 45 CFR § 155.7059(b)(7). Though the annual deductible limits were repealed, employers continue to have more flexibility in how metal levels of coverage are defined because employer contributions to health savings accounts can be taken into account in determining the level of coverage. PPACA § 1302(d)(2)(B), 42 U.S. Code § 18022(d)(2)(B). Because this is extra flexibility, this does not create an extra requirement group coverage must meet on top of individual coverage requirements in a merged market.

<sup>10</sup> Mark A. Hall and Amy B. Monahan, *Paying for Individual Health Insurance Through Tax-Sheltered Cafeteria Plans*, 47 INQUIRY 252, 259 (2010) (“Beginning in 2014, PPACA will remove much of the legal uncertainty about using Section 125 plans for individual insurance because it will eliminate the most troubling aspect of individual insurance: medical underwriting. It is only because individual insurance in most states is not rated and sold like group insurance that using Section 125 plans in this way might be interpreted as violating HIPAA (as interpreted through the tax code). The new federal law, like the 2007 reform law in Massachusetts, eliminates most medical underwriting and requires insurance to be sold in the two market segments under essentially the same rules. Thus, it seems fairly clear that nationally, as in Massachusetts, Section 125 plans could be used for either type of insurance.”).

## C. FEDERAL GUIDANCE SHUTS THE DOOR

Though the ACA provisions outlined above appear to allow employers to pay individual market premiums pre-tax, federal guidance from the Departments of Treasury and Labor effectively bans the practice.<sup>11</sup>

Federal regulators point to two new health plan requirements in the ACA—the prohibition against annual limits on the dollar value of benefits and the requirement to provide preventive services without any cost sharing—which they assert would be violated if employers use a group health plan arrangement to pay individual market premiums.

Why exactly does funding individual market premiums violate these requirements? Using employer payment plans as an example, the guidance cites two reasons:

[T]he employer payment plan will fail to comply with the annual dollar limit prohibition because (1) an employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

The guidance offers a similar two-point rationale for why employer payment plans violate the preventive services requirements. The employer payment plan, by itself, does not fund preventive services and the plan cannot be integrated with individual market coverage to satisfy the preventive services requirement.

So here is what federal regulators appear to be arguing. A group health plan used to pay an individual premium provides a cash payment and this cash payment can never be more than the price of an individual market premium plus some contribution to an HSA or HRA. Thus, there is an annual dollar limit on the cash payment up to the price of the insurance premium and HSA/HRA contribution. Being a cash payment, it also does not provide for preventive services without cost sharing. Next, a group health plan cannot be integrated with an individual health insurance policy to satisfy the annual dollar limit and preventive service requirements, even though the individual policy would satisfy the two requirements.

By not allowing a group health plan to integrate with individual market coverage, the guidance then prohibits any and all defined contribution health plans established to fund individual market coverage pre-tax.

## D. ONGOING AMBIGUITY

Creative techniques to circumvent the guidance have been advanced and some employee benefit companies continue to sell employers services that facilitate pre-tax payment for individual

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<sup>11</sup> IRS Notice 2013-54, 2013-40 I.R.B. 287; and DOL Technical Release No. 2013-03 (September 13, 2013).

insurance premiums, which they argue complies with the guidance.<sup>12</sup> Some gray area arguably remained after the initial publication of the guidance. After all, the guidance does not specifically retract Rev. Rul. 61-146 allowing pre-tax payments for individual coverage.

Since releasing the guidance, federal agencies have attempted to clarify it on three separate occasions, the most recent being IRS Notice 2015-17 issued in February 2015.<sup>13</sup> Each clarification repeats the federal agencies' position that arrangements to reimburse employees for individual insurance premiums violate the prohibition against annual dollar limits on the value of benefits and preventive services requirements. For added emphasis, the IRS has clearly spelled out the possible penalty for a violation—“a \$100/day excise tax per applicable employee (which is \$36,500 per year, per employee).”<sup>14</sup>

The February 2015 guidance also discussed the application of Rev. Rul. 61-146. It affirmed that the ruling “continues to apply,” which suggests there may still be an opportunity to take advantage of the tax exclusion. However, in the next sentence the guidance counsels that Rev. Rul. 61-146 “does not address the application of the market reforms and should not be read as containing any implication regarding the application of the market reforms.” It then proceeds to reiterate that employer arrangements to reimburse individual market premiums violate the market reforms. So, apparently employers can still technically exclude individual market premium reimbursements from income, but they will be subject to a hefty excise tax for violating the market reforms if they choose to do so.

In addition to these government agency publications, a *New York Times* article cites an email from a Treasury Department official who affirms that arrangements to reimburse individual market premiums “generally would fail to comply with the A.C.A.’s prohibition on annual dollar limits.”<sup>15</sup> Also, various blogs posted by benefits administrators reference public and private statements made by IRS representatives who say the IRS intends to prohibit every defined

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<sup>12</sup> Robb Mandelbaum, *Risking a Health Insurance Strategy the I.R.S. May Not Approve*, N. Y. TIMES, June 4, 2014. According to Mandelbaum, Zane Benefits argues insurance premiums are not considered essential health benefits and, therefore, are not subject to the prohibition on annual dollar limits. In order to meet the preventive services requirement, a type of self-insured arrangement is created with a promise to pay preventive services coupled with payment of individual insurance premiums. If an employer requires proof of maintaining an insurance policy with minimum essential coverage that covers preventive services, then there is little to no risk the employer will ever have to pay preventive services. See also Zane Benefits, *A Guide to Health Reimbursement Plans*, Zane Benefits, <http://www.zanebenefits.com/education/health-reimbursement-plans-overview> (accessed November 24, 2015); and Amanda Armstrong, *Individual Health Insurance Reimbursement for Small Practices*, ZANE BENEFITS EMPLOYEE HEALTH BENEFITS AND INSURANCE BLOG (November 24, 2014), <http://www.zanebenefits.com/blog/individual-health-insurance-reimbursement-for-small-practices>.

<sup>13</sup> IRS Notice 2015-17, 2015-14 I.R.B. 845, available at <https://www.irs.gov/pub/irs-drop/n-15-17.pdf>; *FAQs about Affordable Care Act Implementation (Part XXII)*, U.S. Dep’t of Labor, November 6, 2014, <http://www.dol.gov/ebsa/faqs/faq-aca22.html>; *FAQs about Affordable Care Act Implementation (Part XXII)*, Centers for Medicare and Medicaid Services (November 6, 2014), available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>; and *Employer Health Care Arrangements*, I.R.S., first posted online in May 13, 2014 and last modified April 16, 2015, <http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements>.

<sup>14</sup> *Employer Health Care Arrangements supra note 13*.

<sup>15</sup> Mandelbaum *supra note 12*.

contribution strategy to pay individual market premiums through an employer on a pre-tax basis.<sup>16</sup>

These agency clarifications and unofficial statements make clear the agencies *want* to stop employers from funding individual market coverage pre-tax.<sup>17</sup> Nonetheless, as noted above some employee benefit companies continue to argue with some merit that they can create certain defined contribution arrangements to work around the guidance.<sup>18</sup> The IRS is well aware of the argument, but failed to address it in their most recent guidance, which strongly suggests the IRS is consciously leaving this issue unsettled.<sup>19</sup>

But these unsettled arrangements are still just overly complicated workarounds. Clarity on them would not fix the clear legal conflict between the guidance and federal law discussed in Part II. Thus, even if the IRS approved of them, the guidance would still restrict other types of simpler, more flexible and more efficient defined contribution health plan arrangements. That much is clear.

Right now most employee benefit companies are not willing to risk a fight with the IRS. And so most employers are likely receiving and acting on advice like the following from a benefits administrator blog: “No matter how convincing an argument is presented to you regarding the continuing validity of a Defined Contribution Health Strategy utilizing individual insurance plans, we believe the only prudent course is to let someone else’s company or client risk fighting that battle with the IRS.”

Considering the impact of the guidance on employers, employees and their access to a competitive insurance market, it is critical to assess the basis for the guidance and whether it is open to legal challenge or some other strategy to revive opportunities to fund individual insurance pre-tax.

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<sup>16</sup> See Ric Joyner, *Warning! Those that wanted to drop group insurance coverage and use a PRA or HRA to write individual coverage are dealt a blow in this notice. PRAs in Section 125 are now AFTER TAX versus PRE-TAX!*, BENEFIT BLOG, September 17, 2013, <http://benefitblog.com/2013/warning-those-that-wanted-to-drop-group-insurance-coverage-and-use-a-pra-to-write-individual-coverage-are-dealt-a-blow-in-this-notice-pras-in-section-125-are-now-after-tax-versus-pre-tax/>; and *A Major Blow To Defined Contribution Health Strategies*, THEADMINAMERICAN, September 18, 2013, <http://theadminamerican.wordpress.com/2013/09/18/a-major-blow-to-defined-contribution-health-strategies/>.

<sup>17</sup> Mandelbaum *supra* note 12 (“It is abundantly clear that the I.R.S. thinks that you cannot use one of these arrangements to use tax-free dollars to pay for individual health insurance,” said Amy B. Monahan, a law professor at the University of Minnesota.”)

<sup>18</sup> *Id.*

<sup>19</sup> Note that clarity on this argument—the argument that individual insurance premiums are not essential health benefits and therefore not subject to the annual dollar limit prohibition—would not fix the clear legal conflict between the guidance and federal law discussed in Part II. Thus, even if the IRS approved of this type of arrangement, the guidance would still restrict other types of simpler, more flexible and more efficient defined contribution health plan arrangements.



## II. THE LEGAL AND POLICY RATIONALE FOR THE FEDERAL GUIDANCE

The guidance represents a sharp reversal in federal policy. Without any change to the tax code or the 1961 IRS ruling, the Departments of Treasury and Labor have effectively eliminated long-running health plan arrangements in which group health plans pay individual market premiums and the accompanying tax exclusion for those payments.<sup>20</sup> What is the government's rationale for this policy reversal? The following analysis shows there is little legal basis to support barring employers from funding individual market premiums. There are, however, some understandable policy concerns.

### A. NO LEGAL RATIONALE GIVEN

The guidance takes three positions that are relevant to the analysis here: 1) Group health plans used to pay individual insurance premiums violate the annual dollar limit and preventive services requirements;<sup>21</sup> 2) Group health plans *cannot* be integrated with the payment of individual health insurance policies to satisfy the requirements;<sup>22</sup> and 3) Group health plans *can* be integrated with the payment of group health coverage, even coverage from a different employer, to satisfy the requirements.<sup>23</sup> These positions prompt an obvious question: Why can a group health plan be integrated with group coverage, but not individual coverage? What is the legal distinction?

It's hard to understand the distinction. The annual dollar limit and preventive services requirements apply to both group and individual market coverage in exactly the same way. Consequently, an employer-funded health plan integrated with individual market coverage will provide employees with the same annual dollar limit protection and the same preventive services with no out-of-pocket costs as a plan integrated with group coverage. Notably, the interim final regulations, also cited by the guidance, do not make a distinction.<sup>24</sup>

For support, the only authority the regulators cite is a Frequently Asked Questions (FAQ) document issued by the Department of Labor in January 2013 that offers a one sentence answer basically saying “no you can't” without any further explanation.<sup>25</sup> The sentence reads: “The

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<sup>20</sup> Though these defined contribution health plan arrangements were never widespread, the impact of the federal guidance is still substantial. After the ACA removed the main obstacles, the number of employers offering defined contribution health plans and the number of private exchanges to administer them were poised to grow many fold. The guidance shuts down this potential growth.

<sup>21</sup> IRS Notice 2013-54, at 6, 2013-40 I.R.B. 287, at 289.

<sup>22</sup> *Id.*

<sup>23</sup> IRS Notice 2013-54, at 7-9, 2013-40 I.R.B. 287, at 289-291.

<sup>24</sup> The regulations use Health Reimbursement Arrangements (HRA) as an example of an “account-based health plan” to explain how these plans would be treated under the annual dollar limit prohibition. According to the interim regulations, “When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of [the annual dollar limit prohibition], the fact that benefits under the HRA by itself are limited does not violate [the annual dollar limit prohibition] because the combined benefit satisfies the requirements.” Here, the interim regulations reference “other coverage” and does not make a distinction between group and individual coverage. Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37190-91 (June 28, 2010), available at <http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf>.

<sup>25</sup> *FAQs about Affordable Care Act Implementation Part XI*, U.S. Dep't of Labor (January 24, 2013), <http://www.dol.gov/ebsa/faqs/faq-aca11.html>.

Departments intend to issue guidance providing that for purposes of PHS Act section 2711, an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore will violate PHS Act section 2711.”<sup>26</sup>

Like the guidance, the FAQ offers no rationale for the distinction between integrating with individual coverage and integrating with group coverage. Without a rationale, the regulator’s position basically amounts to them arguing group health plans cannot be integrated with individual health insurance policies “because we said so.” To say the least, this is not a firm legal foundation.

## B. GUIDANCE CONTRADICTS FEDERAL COURT AND AGENCY HOLDINGS

While the Obama administration has not offered an official rationale, they did try to explain themselves in private talks with the U.S. Chamber of Commerce, according to a letter the U.S. Chamber sent to the Obama administration.<sup>27</sup> To explain why an employer subsidy can be integrated with group coverage but not individual coverage, the Obama administration argued an employer subsidy and group coverage can be “treated as a single program” because they are both considered a “group health plan,” but the same is not true when combining an employer subsidy with individual coverage.<sup>28</sup> This claim does not square with prior court opinions and federal agency holdings.

### 1. Courts Hold Group Health Plans Integrate with Individual Insurance Coverage

Contrary to the administration’s position, federal courts have found various types of individual insurance coverage, including health insurance, can indeed be integrated with a group plan as part of a single program. Both the ACA and the Health Insurance Portability and Accountability Act (HIPAA) define a group health plan as an “employee welfare benefit plan” as defined by the Employee Retirement Income Security Act (ERISA), often called an ERISA plan.<sup>29</sup> Thus, the ACA carries forward the same definition of employee welfare benefit plan that agencies and courts have used for forty years. In that time, when determining whether or not an ERISA plan exists, federal courts have found little difficulty concluding an ERISA plan can integrate with individual insurance coverage.<sup>30</sup>

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<sup>26</sup> *Id.*

<sup>27</sup> Letter, Randel K. Johnson and Katie Mahoney, U.S. Chamber of Commerce, *Re: Legality of Employer Subsidies for Individual Health Insurance*, May 20, 2013, available at <https://www.uschamber.com/comment/hra-faq-legality-employer-subsidies-individual-health-insurance>.

<sup>28</sup> *Id.*

<sup>29</sup> The ACA adopts by reference the HIPAA definition of group health plan. PPACA § 1301 (b)(3), 42 U.S. Code § 18021 (b)(3). HIPAA then defines a group health plan as an employee welfare benefit plan as defined by ERISA. HIPAA § 2791 (a)(1), 42 U.S. Code § 300gg-91 (a)(1); and ERISA § 3 (1), 29 U.S. Code § 1002 (1).

<sup>30</sup> Case law in this area primarily involves instances where an insurance company uses ERISA to shield itself from state law claims for insurance policy benefits. ERISA generally preempts state laws related to employee benefit plans, including disputes over benefits, which frees insurers from any liability under state fraud, contract and bad faith claims. *See* Massachusetts Casualty Insurance Co. v. Reynolds, 113 F.3d 1450, 1453 (6th Cir.1997) (finding individual disability insurance policies purchased for five or six employees were part of an employee benefit plan governed by ERISA); Peterson v. American Life & Health Ins. Co., 48 F.3d 404 (9th Circ. 1995); Agrawal v. Paul

*Massachusetts Casualty Insurance Co. v. Reynolds* provides the best example where a court held that an individual insurance policy is part of an employee benefit plan. In *Reynolds*, the 6th Circuit held an individual disability insurance policy purchased by an employer continued to be governed by ERISA even after the employee left the company and continued paying their own premiums.<sup>31</sup> More recently, a district court in Kansas held an individual health insurance policy issued to a business owner was part of an ERISA plan because the business funded other individual insurance policies.<sup>32</sup> In these and other federal cases—and directly contrary to the Obama administration’s legal position—federal courts integrated an individual insurance policy with a group employee benefit plan and treated them as part of a *single program*.

## 2. Agencies Hold Individual Insurance Can Be Subject to Group Insurance Regulations

Federal agencies also find individual coverage can be part of a group health plan under certain circumstances. Citing the *Reynolds* case discussed above, a Health Care Financing Administration (HCFA) memorandum takes the position that “an individual policy under State law may nonetheless be subject to the group market requirements contained in [HIPAA], if the coverage is provided in connection with a group health plan.”<sup>33</sup> In effect, this holding explains how to regulate insurance coverage when an individual policy is integrated with a group health plan. The memo makes utterly no sense if individual policies can’t mix and integrate with group health plans.

A 2011 CMS memorandum also explained when to apply federal individual and group market regulations.<sup>34</sup> This time in the context of association health plans. The memorandum recognized

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Revere Life Ins. Co., 205 F. 3d 297 (6th Cir. 2000) (“In *Massachusetts Casualty Insurance Co. v. Reynolds*, 113 F.3d 1450, 1453 (6th Cir.1997), we acknowledged that an ERISA plan can consist of individual disability insurance policies covering each of the employer’s employees, rather than a group policy.”); *Provident Life & Accident Co. v. Sharpless*, 253 F.Supp.2d 874 (M.D. La. 2003), affirmed, 364 F.3d 634 (5th Cir.2004) (treating individually issued disability insurance policies as part of an employee benefit plan); *Madonia v. Blue Cross & Blue Shield of Va.*, 11 F.3d 444, 447 (4th Cir.1993); *Sipma v. Massachusetts Cas. Ins. Co.*, 256 F. 3d 1006 (10th Cir. 2001) (finding individual disability policies were part of an employee benefit plan); *Shultz v. Blue Cross and Blue Shield of Kansas, Inc.*, Case 6:09-cv-01220 (D. Kansas 2009) (rejecting plaintiffs claim that her disability insurance was not part an ERISA plan because the the policy was specifically designated as a ‘non group’ plan and was not dependent upon employment”); *Spillane v. AXA Financial, Inc.*, 2009 WL 2215078 (E.D. Pa. July 22, 2009); *Berry v. Provident Life & Assoc. Ins. Co.*, No. 05 Civ. 4139 (D.S.D. June 19, 2007) (individual disability insurance policy).

<sup>31</sup> *Reynolds*, 113 F.3d 1450. It can be difficult to determine from the facts presented in a case whether an insurance policy was issued individually or as a group. In this case, it was very clear because the Court corrected the plaintiff after they argued the policy was originally issued as a group policy. *Id.* at 1453 (“[Plaintiff] contends, however, that the disability insurance coverage purchased by [his employer] Navarre was a ‘group policy,’ and that when he left Navarre and began making the premium payments himself the policy was ‘converted’ to an individual policy not governed by ERISA. . . . We are not persuaded that Mr. Reynolds’ post-employment coverage was “conversion” coverage. As stated above, Navarre did not buy a group policy.”).

<sup>32</sup> *Shultz v. Blue Cross and Blue Shield of Kansas, Inc.*, Case 6:09-cv-01220 (D. Kansas 2009).

<sup>33</sup> U.S. Dep’t of Health and Human Services Program Memorandum 00-06 (November 2000), available at <http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthinsReformforConsume/downloads/HIPAA-00-06.pdf>.

<sup>34</sup> Memorandum, Centers for Medicare and Medicaid Services, “Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through,

the existence of “mixed” associations “where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under [federal law], as determined by each member’s circumstances.”<sup>35</sup> This reflects a consistent position from the federal government that groups and individuals can mix and integrate.

Clearly, federal courts and agencies do not find a problem with integrating individual coverage with a group health plan into a “single program” in order to subject the individual coverage to the requirements of ERISA and HIPAA. In the same way, individual coverage provided in connection with a group health plan should be “taken as a whole” and treated as a single program for the purposes of satisfying the annual dollar limit and preventive services requirements.<sup>36</sup> The Obama administration, nonetheless, takes the contrary position and offers no support for this direct departure from prior federal court and agency positions.

### C. CONGRESS NEVER INTENDED THIS OUTCOME

Any legal foundation that might exist crumbles after considering the text and other provisions of the ACA, as well as congressional explanations of those provisions issued at the time of passage. In 1850, Chief Justice Taney explained, “In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.”<sup>37</sup> As a whole, the ACA reveals Congress never intended this outcome and even envisioned employers funding individual coverage pre-tax under the law.

#### 1. No Plain Language

Looking to the text, there’s no plain language to support the position that Congress intended to end the practice of employers paying individual market premiums pre-tax through a group health plan.<sup>38</sup> Writing for the majority in *Whitman v. American Trucking Association*, Justice Scalia colorfully states, “Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes.”<sup>39</sup> Nevertheless, the guidance basically holds that Congress eliminated a fundamental, long-standing health plan arrangement and its associated tax exclusion when it passed certain ancillary insurance requirements.<sup>40</sup> This is not how Congress amends laws.

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Associations”, September 1, 2011, available at [https://www.cms.gov/CCIIO/Resources/Files/Downloads/association\\_coverage\\_9\\_1\\_2011.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf).

<sup>35</sup> *Id* at 3. See also Centers for Medicare and Medicaid Services Services, Program Memorandum Transmittal No. 02-02 (August 2002), available at <https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/HIPAA-02-02.pdf>.

<sup>36</sup> *Peterson*, 48 F.3d at 407 (concluding an insurance policy held by a single employee “was just one component of Quivira's employee benefit program and that the program, *taken as a whole*, constitutes an ERISA plan.” [emphasis added]).

<sup>37</sup> *United States v. Boisdore's Heirs*, 49 U.S. 113, 122 (1850).

<sup>38</sup> The language was not plain to the Congressional Budget Office. They never scored the fiscal impact of eliminating the tax exclusion for employer payments for individual market premiums.

<sup>39</sup> *Whitman v. American Trucking Assns., Inc.*, 531 U.S. 457 (2001).

<sup>40</sup> Though the practice isn’t widespread, it is well known and dates back to at least 1961 when the IRS gave it their official stamp of approval. The IRS issued additional guidance affirming the use of health reimbursement

Congress knows how to eliminate a health plan arrangement and a tax exclusion and likely would have been very clear if they intended to end one with such a long history.<sup>41</sup>

## 2. Guidance Conflicts with Various ACA Provisions

On top of no plain or even implicit language, at least four ACA provisions undermine the guidance and reveal that Congress intended and assumed employers would continue to exclude individual market premiums from income under a group health plan.

### *a. The ACA Allows Individual and Small Group Markets to Merge*

The ACA guarantees to states the flexibility to merge their individual and small group markets, as well as their individual and small business exchanges. One of the main approaches to merging markets is to remove small groups below a certain size from the group market and then merge the group members into the individual market, resulting in employers paying for individual market coverage.<sup>42</sup> Thus, Congress clearly envisioned people in small group health plans using their employer plan to pay individual market premiums pre-tax.<sup>43</sup>

### *b. The ACA Bars Using Cafeteria Plans to Fund Individual Coverage in an Exchange*

The ACA specifically forbids the use of cafeteria plans—also known as Section 125 plans—to fund individual market premiums in an exchange.<sup>44</sup> “If it was impermissible to pay for such individual policies through a cafeteria plan,” argues University of Minnesota law professor Amy Monahan, “there would be no need to amend section 125 only for exchange-based policies.”<sup>45</sup> Therefore, by saying no to using cafeteria plans to pay individual market premiums in the exchange, Congress must have been saying yes to using cafeteria plans outside the exchange. If group health plans cannot be integrated with *any* individual market coverage, then it is entirely

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arrangements to pay individual market premiums in 2002 and, in 2007, affirmed payment through Section 125 cafeteria plans.

<sup>41</sup> See *Central Bank of Denver v. First Interstate Bank*, 511 U.S. 164, 176-77 (1994).

<sup>42</sup> AMERICAN ACADEMY OF ACTUARIES, *CRITICAL ISSUES IN HEALTH REFORM: MERGING THE SMALL GROUP AND INDIVIDUAL MARKETS* (September 2009), available at [http://www.actuary.org/files/publications/merging\\_markets\\_sept2009.pdf](http://www.actuary.org/files/publications/merging_markets_sept2009.pdf). As explained by the executive director of Minnesota’s health exchange before a committee in the Minnesota Senate, “Merged markets would allow defined contribution into [the] individual market for true portability.” April Todd-Malmlov, *Minnesota Health Insurance Exchange Testimony* (January 16, 2013), available at <http://www.mnsure.org/images/PRES-2013-01-16-SenateCmtee.pdf>.

<sup>43</sup> There is a second approach to merging markets. A state could maintain the group market structure and merge individuals into the group market as groups of one. This is how the state of Massachusetts merged its markets in 2006. While this approach would not result in an employer paying individual market premiums as such, it does eliminate the distinction between individual and small group market policies. Thus, even if this was the only approach Congress had in mind, Congress still envisioned states eliminating the difference between the individual and small group markets. Maintaining a distinction for tax purposes would not be possible in this context.

<sup>44</sup> PPACA § 1515, I.R.C. § 125(f)(3).

<sup>45</sup> AMY B. MONAHAN, *STATE HEALTH ACCESS REFORM EVALUATION, SECTION 125 PLANS IN THE POST-REFORM ENVIRONMENT: ISSUES FOR INDIVIDUAL INSURANCE* (June 2010), available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2010/rwjf61223](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf61223).

unnecessary for the ACA to prohibit cafeteria plans from funding individual coverage in the exchange. Courts disfavor rendering federal laws unnecessary and superfluous.<sup>46</sup>

*c. The ACA Forces Congress to Obtain Coverage through an Exchange*

The ACA requires all members of Congress and their staff to obtain coverage through an Exchange.<sup>47</sup> Because Congress employs more than 50 people, it would not qualify as a small group and so members of Congress likely intended to obtain individual market coverage for themselves and their staff, not group coverage. Even if Congress can squeeze 535 members and staff into the small business exchange, the law still allows Congress to use the individual market exchange. And, in August 2013, the Office of Personnel Management (OPM) was actually arranging to enroll Congress and their staff in the individual market through Exchanges.<sup>48</sup> Notably, OPM affirmed that employer contributions would continue to be excluded from taxable income.<sup>49</sup> Of course, this arrangement directly conflicts with the Departments of Treasury and Labor guidance issued just over a month later. The Obama administration's left and right hands were apparently oblivious to the regulations each was writing, but that was quickly corrected. The final rule on congressional health benefits changed course and now requires Congress and staff to enroll in the District of Columbia small business exchange.<sup>50</sup>

*d. The ACA Required Employers to Fund Individual Coverage*

As passed the ACA required employers to fund individual health plans for certain employees. Though repealed in 2011,<sup>51</sup> the ACA originally required employers to offer "free choice vouchers" to certain employees when their contribution to their employer's health plan became unaffordable.<sup>52</sup> The vouchers could then be used to buy health insurance through the individual market insurance exchange. There is no functional difference between a Free Choice Voucher and a defined contribution "group" health plan set up to fund individual market premiums.<sup>53</sup> In

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<sup>46</sup> *Sprietsma v. Mercury Marine*, 537 U.S. 51, 63 (2003); and *Astoria Federal Savings & Loan Ass'n v. Solimino*, 501 U.S. 104, 112 (1991).

<sup>47</sup> PPACA § 1312(d), 42 U.S. Code § 18032(d).

<sup>48</sup> U.S. Office of Personnel Management, News Release, OPM Issues Proposed Rule Which Details How Members of Congress and Congressional Staff will be Insured through the Health Insurance Exchanges, August 7, 2013, available at <http://www.opm.gov/news/releases/2013/08/opm-issues-proposed-rule-which-details-how-members-of-congress-and-congressional-staff-will-be-insured-through-the-health-insurance-exchanges/>.

<sup>49</sup> *Id.* But see Robert E. Moffit, Edmund F. Haislmaier and Joseph A. Morris, *Congress in the Obamacare Trap: No Easy Escape*, THE HERITAGE FOUNDATION BACKGROUNDER #2831 (August 2, 2013), available at <http://www.heritage.org/research/reports/2013/08/congress-in-the-obamacare-trap-no-easy-escape> (arguing the ACA "requires [congressional] Members and staff to either pay for their own health insurance out of their after-tax incomes").

<sup>50</sup> U.S. Office of Personnel Management Benefits Administration Letter No. 13-207 (September 30, 2013), available at <http://www.opm.gov/retirement-services/publications-forms/benefits-administration-letters/2013/13-207.pdf>.

<sup>51</sup> Eric Lichtblau, *Lobbyists Won Key Concessions in Budget Deal*, N. Y. TIMES, April 12, 2011, available at <http://www.nytimes.com/2011/04/13/us/politics/13lobby.html>.

<sup>52</sup> PPACA § 10108.

<sup>53</sup> This is especially true if a free choice voucher were considered a component of the employer's group health plan. If so, it would fall under the annual dollar limit and preventive services requirements just the same as a defined contribution health plan. The ACA specifically excluded free choice vouchers from employee income and allowed the employer a deduction for the vouchers. Someone might argue this demonstrates at least a difference in the tax

both instances, an employer is simply giving their employee cash to buy individual insurance. And in both instances the individual coverage purchased satisfies the annual dollar limit and preventive services requirements. It strains common sense to think Congress intended that a cash contribution through a defined contribution health plan violates the requirements when an equivalent cash contribution through a free choice voucher does not.

### 3. Guidance Does Not Square with Congress's Technical Explanation

The day the ACA passed in the House, Congress's Joint Committee on Taxation (JCT) published a "Technical Explanation" of the revenue provisions in the ACA, which strongly supports a congressional intent to continue allowing employers to fund individual market premiums.<sup>54</sup> For each ACA provision, the report details the present law in force at the time the ACA passed and then explains the new ACA provision within that context. Ahead of explaining both the employer mandate provisions and certain cafeteria plan provisions, the JCT highlights that employers can reimburse individual market premiums pre-tax under present law. Specifically, the JCT states, "One way that employers can offer employer-provided health insurance coverage for purposes of the tax exclusion is to offer to reimburse employees for the premiums for health insurance purchased by employees in the individual health insurance market."<sup>55</sup>

The most reasonable purpose for highlighting this option is to assure employers that the option is still available after the passage of the ACA. In the context of the employer mandate, there would no doubt be questions and uncertainty over whether reimbursing individual market premiums can satisfy the mandate. The JCT makes clear that reimbursing individual market premiums is one type of employer-provided health insurance coverage. As such, employers can satisfy the mandate by offering to reimburse individual market premiums. If it were otherwise, the JCT would have clearly explained any change to present law wrought by the ACA.

In discussing how the ACA changed cafeteria plans, the JCT explains how employers cannot use a cafeteria plan to reimburse an employee for premiums for individual market coverage purchased on the Exchange.<sup>56</sup> So, after explaining the present law, the only change to present law noted by the JCT to cafeteria plans is a restriction tied exclusively to individual coverage purchased on an Exchange. The clear implication is that the law present at the time the ACA passed carries forward and continues to allow employers to reimburse employee premiums for individual market coverage purchased outside an Exchange.

If Congress intended the market reforms to restrict employers from reimbursing individual market premiums, the JCT would have noted that change in its discussion of the ACA's market reforms. Yet when the JCT identified how the IRS code imposes a \$100 per day per failure

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treatment. But this was only necessary because the law allowed employees to retain any portion of the voucher that exceeded the insurance premium payment and, as such, needed to make clear that any money retained by the employee was taxable income. Otherwise, the tax treatment is functionally the same.

<sup>54</sup> JOINT COMM. ON TAXATION, U.S. CONG., *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act,"* (March 21, 2010), available at <https://www.jct.gov/publications.html?func=startdown&id=3673>.

<sup>55</sup> *Id.* at 37 and 47.

<sup>56</sup> *Id.* at 47 to 48.

excise tax on employers for failures to follow ERISA requirements and explained how that excise tax now applies to failures to follow the new ACA market reform requirements, it never hints that these new requirements might apply differently to employer-provided health insurance coverage when it funds individual market premiums and, as a result, subjects employers to this tax.<sup>57</sup>

Ultimately, there's little legal basis to prohibit employers from excluding individual market premium payments from income. In fact, provisions in the ACA suggest Congress expected and intended that the exclusion would continue. Without a legal basis, it is fair to conclude that the prohibition is aimed at addressing certain policy concerns and not aimed at faithfully executing the text of the ACA.

#### D. THE POLICY CONCERNS

While the Obama administration has not officially expressed their policy concerns, they did identify two concerns in their private conversations with the U.S. Chamber. First, the Obama administration “expressed concerns that permitting employers to subsidize individual market coverage would encourage employers with sicker-than-average work forces to abandon the group insurance market.”<sup>58</sup> Second, the administration is “concerned about double dipping, i.e., letting employees buy federally subsidized coverage on the exchanges with tax-free employer reimbursement.”<sup>59</sup>

Both are legitimate concerns. Insurers are still free to base large group pricing on the group's risk, which can result in very expensive premiums. Now that the major obstacles to an employer funding individual market health coverage are gone, some higher-risk large groups will no doubt find less expensive premiums on the individual market and opt to fund individual market policies for their employees. Large employers might also try to structure their health benefits to encourage sicker, high risk employees to opt for individual coverage while retaining healthier employees in the group plan.<sup>60</sup> High risk employees from large employers entering the individual market will increase the risk profile of the individual pool, which would, in turn, raise premiums and lower coverage rates.<sup>61</sup>

As for double dipping, recall how the ACA specifically bans using Section 125 cafeteria plans to fund individual health plans in the exchange. It does not similarly ban the use of other pre-tax funding arrangements, such as HRAs, which strongly suggests these pre-tax arrangements are not banned from being used with the exchange. Thus, it is conceivable that a small employer not subject to the employer mandate could establish an account to exclusively pay insurance premiums, but without enough funds to cover the cost of an affordable health plan. By not providing access to an affordable health plan, this arrangement might allow their employees to

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<sup>57</sup> *Id.* at 38, 48 to 50.

<sup>58</sup> Johnson & Mahoney *supra* note 27.

<sup>59</sup> *Id.*

<sup>60</sup> See Amy Monahan and Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VIRGINIA LAW REVIEW 125 (2011).

<sup>61</sup> *Id.*



use tax credits in the exchange and then use their employer account to pay any remaining premium with pre-tax dollars.

The Obama administration may have another unstated policy goal in mind: They may intend to encourage more businesses to use the small business exchange by limiting the defined contribution health plan options outside the exchanges. There's good reason to be concerned that small businesses won't use the exchange. Massachusetts found very little interest in their small business exchange.<sup>62</sup> Banning employers from funding individual market premiums with pre-tax dollars substantially limits an employer's defined contribution health plan options, which should increase demand for the small business exchange. The February 2015 guidance actually makes this point, stating that though the 2013 guidance restricts small employers from offering the defined contribution health plans they had in the past, the small business exchange "addresses many of the concerns of small employers." Thus, the IRS essentially confesses the ACA small business exchanges are where they want small businesses to go for defined contribution.

Importantly, these policy goals are entirely unrelated to the policy goals of the two insurance requirements the guidance is enforcing. The annual dollar limit prohibition aims to limit financial exposure for people who become seriously ill or injured and the preventive services requirements aim to increase access to preventive services. The fact that the only discernable policy goals of restricting group health plans from funding individual market premiums do not advance the policy goals of the two insurance requirements further undermines the legal basis for the guidance.

### III. A LEGAL RESPONSE AND STATE POLICY RESPONSE TO THE GUIDANCE

Understanding both the legal arguments and the policy concerns informs how various people and entities can respond. A direct legal challenge is the most obvious way to respond, considering the lack of a sound legal basis for the guidance. But a lawsuit will take years to process with no guarantee of success. It's also a combative approach, which will not appeal to supporters of the ACA and will not address the federal government's policy concerns.

Because states retain power to regulate and structure insurance markets, they retain the power to adopt a more constructive and collaborative policy response. Specifically, states can create a new type of group insurance coverage to accept pre-tax contributions from employers that seamlessly converts to and from individual coverage with changes in employment status, thereby retaining the ownership and portability characteristics of traditional individual coverage. These legal and policy responses are developed in more detail below.

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<sup>62</sup> About 10 percent of those with private coverage in the Massachusetts Connector are covered through small businesses and most of those businesses are "micro-businesses," averaging only 1.5 employees. Mark A. Hall, *Employers' Use of Health Insurance Exchanges: Lessons from Massachusetts*, 6 ST. LOUIS U. J. OF HEALTH L. & POL'Y, Vol. 355, 356 (2013), available at [http://slu.edu/Documents/law/SLUJHP/Hall\\_Article.pdf](http://slu.edu/Documents/law/SLUJHP/Hall_Article.pdf).

## A. GUIDANCE INVITES A LEGAL CHALLENGE

Based on the legal analysis outlined in Part II, the guidance issued by the federal agencies is open to a strong legal challenge. To review, federal regulators gave no rationale to justify why a group health plan can be integrated with group insurance coverage and not with individual coverage—the basis for their holding. Not only is there no rationale, but their approach directly conflicts with prior federal judicial and agency opinions that, under certain circumstances, treat individual insurance policies as one part of an integrated group health plan.

Furthermore, there is no plain language in the ACA even hinting at a congressional intent to eliminate the long-standing tax exclusion available for employer contributions to individual market premiums. Rather, four provisions in the ACA show Congress intended quite the opposite. Congress envisioned employers funding individual market premiums in merged markets. Congress envisioned employers continuing to fund individual market premiums through cafeteria plans outside the exchange. Congress envisioned funding individual market premiums pre-tax for its own members and staff. And Congress even envisioned (and required) employers to fund individual health plans with pre-tax dollars for certain employees. Congress's intent is further evidenced by their Joint Committee on Taxation technical explanation of the ACA's revenue provisions, which never expresses any change to an employer's defined contribution health plan options.

Together, these arguments form the basis of a strong legal challenge to the federal government's authority to ban employers from funding individual market premiums. Despite the weakness of the federal government's position, a legal challenge will face difficulties.

### 1. Little Incentive for a Plaintiff to Challenge

One major problem with a legal challenge is the lack of a strong incentive for a plaintiff to come forward and mount a challenge. Potential challengers include employers, employer associations, benefit companies and even Congress. None of these entities have a strong incentive to challenge the guidance. The immediate benefits of winning the legal challenge simply do not justify the hundreds of thousands of dollars it would cost any single employer. An employer association could afford it, but most employer associations are more concerned about getting along with regulators than challenging them. The National Federation of Independent Business is one possible exception. Benefit companies that claim legal ambiguity still exists and continue to facilitate funding individual premiums with employer dollars likely prefer the status quo to the risk of losing a legal challenge. A loss would completely undermine their core business operation. Finally, Congress would likely prefer to avoid a challenge because it would reopen the controversial issue over whether Members and staff should continue to qualify for subsidies to buy health coverage on the insurance exchange.<sup>63</sup>

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<sup>63</sup> Patrick Marley, *Appeals court affirms dismissal of Ron Johnson's Obamacare lawsuit*, MILWAUKEE WISCONSIN JOURNAL SENTINEL, April 14, 2015, available at <http://www.jsonline.com/news/statepolitics/appeals-court-affirms-dismissal-of-ron-johnsons-obamacare-lawsuit-b99481183z1-299707121.html>; Ed O'Keefe, *38 GOP lawmakers join Ron Johnson's Obamacare lawsuit*, WASHINGTON POST, April 22, 2014, available at <http://www.washingtonpost.com/blogs/post-politics/wp/2014/04/22/38-gop-lawmakers-join-ron-johnsons-obamacare-lawsuit/>; and John Bresnahan and Jake Sherman, *Lawmakers, aides may get Obamacare exemption*,

## 2. Court May Defer to Federal Agencies

A second problem, the general complexity of the law surrounding the federal regulation of health insurance and the tax exclusion for health care costs creates the real chance a court will choose to defer to the federal agencies' position. The apparent simplicity of the fact that a group health plan integrated with either individual or group coverage will equally satisfy the annual dollar limit and the preventive services requirements may get buried in complex arguments over how the ACA alters the structure and regulation of insurance and employee health plans.

A court, however, should not afford federal agencies even limited deference in any future litigation. Courts generally give substantial deference, called *Chevron* deference after the leading Supreme Court case, to administrative interpretations when they go through a formal adjudication or rulemaking process.<sup>64</sup> This heightened deference should not apply here because the guidance did not go through any formal process, such as a notice and comment period. At the very least, courts will give administrative interpretations "weight," but the weight they give is dependent on things like how thoroughly the agency considered their opinion and whether it conflicts with other opinions.<sup>65</sup> In this case, the agencies offer no rationale.<sup>66</sup> Moreover, the guidance is inconsistent with prior agency and court opinions, as well as other provisions in the ACA.<sup>67</sup> Absent any persuasive heft to the agencies' opinion, no weight should be given. Nonetheless, there is still a risk a federal court will complicate the issue and then defer to the agencies.

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POLITICO (April 24, 2013), at <http://www.politico.com/story/2013/04/obamacare-exemption-lawmakers-aides-90610.html>. See also Moffit, Haislmaier & Morris *supra* note 49.

<sup>64</sup> The seminal Supreme Court ruling *Chevron, U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984) instructs courts to give broad deference to an agency's interpretation of a federal statute they are charged with administering. Subsequent case law, however, limits *Chevron* deference only to agency interpretations "promulgated in the exercise of" authority delegated by Congress to the agency to make rules. *Mead* 226-227. See also *Christensen v. Harris County*, 529 U.S. 576, 587 (2000) ("Interpretations such as those in opinion letters—like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law—do not warrant *Chevron*-style deference."). Furthermore, the Supreme Court's recent ruling in *King v. Burwell* continues to limit the application of *Chevron* deference. In *King*, the Court refused to grant *Chevron* deference to the IRS's interpretation that the ACA allowed tax credits to flow through federal insurance exchanges despite statutory language limiting tax credits to people enrolled in a health plan "through an Exchange established by the State." *King v. Burwell*, 576 U.S. \_\_\_ (2015). Billions of dollars in federal spending were at issue and, with those billions in mind, the Court ruled deference does not apply to such "a question of deep economic and political significance." By refusing *Chevron* deference, as Adam White explains, "the Court has significantly reinforced and reinvigorated the 'major questions' doctrine, a doctrine ordinarily associated with conservatives' efforts to restrain the administrative state by infusing the interpretation of regulatory statutes with structural constitutional concerns — namely, that the courts must not presume that Congress delegates vast powers to regulatory agencies through obscure statutes." Adam White, *Symposium: Defining deference down*, SCOTUSBLOG (June 25, 2015), <http://www.scotusblog.com/2015/06/symposium-defining-deference-down/>.

<sup>65</sup> If *Chevron* deference is not applied, then the less deferential standard set out in *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944) applies. Under *Skidmore*, courts give "weight" to administrative interpretations, but the "weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade."

<sup>66</sup> *Supra* Part II. A.

<sup>67</sup> *Supra* Part II. A. & B.

Understanding the weakness of the Obama administration’s legal position, litigation should not be ignored. A successful challenge would free small and large employers all across the country to establish health plans that give their employees more ownership and control, without sacrificing the tax advantages of traditional group health plans. Litigation, though, will take time and there are no guarantees—and that’s assuming a plaintiff comes forward. Because states retain regulatory power over insurance markets, they also retain power to take a more immediate and collaborative approach with federal agencies to revive defined contribution health plan options.

## B. A MORE COLLABORATIVE STATE POLICY RESPONSE

Prior to the ACA passing, states took the lead role in regulating insurance markets. While the breadth of the ACA’s new insurance regulations displaced much of the states’ control over insurance markets, states retain the power to regulate insurance so long as state regulations don’t conflict with federal law.<sup>68</sup> States can use this power to apply a more targeted solution to stop employers from double dipping on tax advantages and at the same time revive the opportunity for employers to offer tax-advantaged defined contribution health plans that connect employees with portable health coverage they can keep when their employment status changes.

### 1. Federal Regulators Could Not Apply a Targeted Solution

Federal regulators maybe wanted to apply a more targeted solution to stop employers and their employees from double dipping on tax advantages and to stop large groups from dumping high risk employees into the individual market. But there was no direct approach available. The latest February 2015 guidance admits the tax exclusion for individual market premiums still exists. And nothing in the ACA directly prohibits employers from funding individual market premiums, something the JCT technical explanation clearly states was an option prior to the ACA.

Without any clear and direct change to the tax exclusion or employer options to offer defined contribution health plans, federal regulators needed to get creative and find legal authority elsewhere. The ACA’s annual dollar limit prohibition and preventive services requirements ended up being the best authority they could find. As explained above, by proclaiming employer payments to individual market premiums violate the two requirements, the Departments of Treasury and Labor effectively (and indirectly) banned employers from making pre-tax payments to individual market premiums without ever needing to touch the tax code.

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<sup>68</sup> PPACA § 1321(d), 42 U.S. Code § 18041(d) (“NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.— Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.”). PPACA further provides: “Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.” PPACA § 1312(d)(2), 42 U.S. Code § 18032(d)(2). ERISA incorporates the ACA’s insurance regulations by reference. PPACA § 1563(e), ERISA § 715, 29 U.S. Code § 1185d. ERISA includes a well-known “savings clause” that saves state insurance regulations from being preempted which similarly reinforces the states continued role in regulating insurance. It states: “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance.” ERISA § 514, 29 U.S. Code § 1144 (b)(2)(A).

Unfortunately, this approach required the federal government to ban *all* employers from making *any* payment to individual market premiums, not just premiums for insurance sold in the exchanges or premiums funded by just large employers. That’s because the two requirements apply equally to small and large employers and apply equally inside and outside the exchange. In the process, employers lost an important strategy for providing health coverage to their employees.

## 2. A State Solution to Revive Opportunities for Employers to Fund Individual Coverage

While limitations on federal regulators’ authority led to a less than ideal solution, states have the authority to basically pick up where federal regulators left off and move to a better, more targeted solution that revives defined contribution health plans to fund individual coverage.

To do so, a state should create a new category of group insurance coverage—hereinafter called portable group coverage—that *merges* elements of individual coverage with elements of group coverage. This new category of coverage would be defined as (1) insurance coverage purchased from the individual market pool and (2) paid in full or in part by an employer. At a minimum, a state must require portable group coverage to meet federal small group market reforms required by 42 U.S. Code Chapter 6A, Subchapter 25, Part A. In this way, the individually-issued coverage funded by an employer becomes group coverage subject to state individual market regulations and federal small group market regulations. What was individual market coverage is now an individualized form of group market coverage.

Once defined as group market coverage under state law, two important things happen. First, as group market coverage, portable group coverage would never qualify for a “premium tax credit” because those tax credits are only available to “qualified health plans offered in the individual market.”<sup>69</sup> This then delivers an alternative state-based solution to eliminate the double-dipping problem.

Second, as group market coverage, it can integrate with group health plan documents and receive pre-tax funding from an employer. Recall, the guidance very clearly states a group health plan “cannot be integrated with any individual health insurance policy purchased under the arrangement.” By redefining the coverage and subjecting the coverage to federal group coverage regulations, the new portable group coverage can integrate with a group health plan established to fund a defined contribution health plan arrangement and satisfy the requirements of the federal guidance.

Though subject to federal group market regulations, portable group coverage would share the same risk pool and product lines as individual coverage. Thus, this would be a *merged market*—essentially individual coverage sold through a group market. While this might seem to be an odd arrangement, the ACA clearly envisions states may want to merge their individual and small group markets into a single risk pool at some point.<sup>70</sup> This is one type of merger and because it “does not prevent the application” of any provision of federal law, the state maintains regulatory

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<sup>69</sup> PPACA § 1401, 26 U.S. Code § 36B.

<sup>70</sup> PPACA § 1312(c)(3), 42 U.S. Code § 18032(c)(3).

authority to do so.<sup>71</sup> In the end, the merger provides the choice, portability and security of individually-issued coverage in combination with a group health plan subject to federal group coverage regulations.

### 3. Primary Considerations in Drafting State Legislation

The preceding outlines the basic approach. There are a number of additional issues and options a state will need to consider when developing a complete strategy to implement portable group coverage. The following outlines the major elements a state should consider when drafting legislation.

#### *a. Limit on Employer Size*

It may be good policy and good politics for states to limit portable group coverage to small employers, considering the federal guidance is in part driven by concerns over large employers dumping sicker employees into the individual market. The concern over adverse selection, however, is speculative and a state may wish to allow large groups to participate. Employer-sponsored plans are likely filled with wealthier and, therefore, healthier enrollees than the individual market. More employers subsidizing individual market policies could be just what the individual market needs to expand its risk pool with healthier enrollees and become more stable and competitive.

States should be free to allow both small and large employers to participate in a portable group market.<sup>72</sup> Participants in the portable group coverage market will continue to be regulated as individuals, small groups and large groups under federal law depending on the status of the participant. However, the distinction will be largely meaningless because nearly identical market requirements will apply to all participants. The application of federal regulations to portable group market participants would be similar to how regulations apply to mixed associations. A 2011 CMS memo recognized the existence of “mixed” associations “where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under [federal law], as determined by each member’s circumstances.”<sup>73</sup>

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<sup>71</sup> HIPAA § 2723 (a)(1), 42 U.S. Code § 300gg-23 (a)(1); and PPACA § 1321(d), 42 U.S. Code § 18041(d)). PPACA further provides: “Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.” PPACA § 1312(d)(2), 42 U.S. Code § 18032(d)(2). ERISA incorporates the ACA’s insurance regulations by reference. PPACA § 1563(e), ERISA § 715, 29 U.S. Code § 1185d. ERISA includes a well-known “savings clause” which similarly reinforces the states continued role in regulating insurance. It states: “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance.” ERISA § 514, 29 U.S. Code § 1144 (b)(2)(A).

<sup>72</sup> There’s no substantial legal difference between a small group health plan and large group health plan that would stop a state from allowing a large group health plan to integrate with portable group coverage. Recall it was, in part, the fear of large employers with sicker employees joining the individual market pool that spurred the federal government to issue guidance holding employer-funded individual market coverage violated the annual dollar limit prohibition and preventive services requirement. If there were some other bar to large employers participating in the individual market, then it never would have been necessary to issue the guidance.

<sup>73</sup> Gary Cohen, Centers for Medicare and Medicaid Services Memorandum, *Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or*

*b. Single Risk Pool for Individual Market and Portable Group Market*

The main idea and benefit of the portable group coverage approach is to allow employers to fund group insurance coverage that shares the same features as individual coverage, including sharing the same risk pool. The current individual market pool becomes a pool of “individually-issued insurance” owned by both individuals and groups. This is one of the fundamental elements of the merger concept.

*c. Retain the Traditional Small Group Market and Pool*

When merging the individual and small group markets into a portable group market, a state may want to retain the traditional small group market. This avoids any immediate and dramatic change to the regulation of the small group market. Small groups are simply given another option, which guarantees a more gradual and less disruptive change. However, as discussed in more detail below, allowing the small group pool to remain is subject to some legal uncertainties that can be avoided by closing the pool.<sup>74</sup> Additionally, leaving the small group pool open may create more opportunity for adverse risk selection because it gives small employers another option to select.

*d. Freedom of Employers to Limit Choice*

Many employers value having control over the design of their health plan in order to help their employees access high quality coverage. Employers generally retain control over their employee benefits. ERISA generally restricts states regulating employee benefits and so employers should still be free to design health plan offerings through a portable group market. However, a state might wish to explore whether ERISA allows any state regulations to guarantee employees have access to purchase coverage from any willing insurer in the portable group market.

*e. Portability*

To guarantee coverage is portable, a state can require automatic conversion to and from individual coverage when employment status changes. In order to be absolutely clear this is group coverage able to be integrated with a group health plan under the federal guidance, a state should require the coverage to be held and owned in the name of the employer and converted to individual ownership when job status changes. If a state allows employers to limit the type of health plan, a state may wish to require employers to at least convert individual policies already owned by new hires.

*f. Alignment of Individual and Group Enrollment Periods*

Enrollment period restrictions present one of the only substantial differences between individual and small group regulations in federal law. Federal regulation requires open enrollment throughout the year in the small group market and restricts enrollment in the individual market to

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*through, Associations*, September 2, 2011, available at [https://www.cms.gov/CCIIO/Resources/Files/Downloads/association\\_coverage\\_9\\_1\\_2011.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf).

<sup>74</sup> *Infra* Part III. 4. b. ii.

November through January. Allowing open enrollment in the portable group market creates a serious risk of adverse selection where employees wait until they are sick to enroll. One solution is to create an additional employee participation guideline—much like requirements that 75 percent of employees participate—requiring employees to choose to sign up for coverage within 30 days of employment to be eligible if they are hired outside the individual market’s open enrollment period. Thus, an employer can choose to enter the portable group market at any time, but after doing so the employer must require any new hires to take up coverage within 30 days of their start date.

*g. Application of State Small Group Market Regulations*

There is no reason a state must apply state small group market regulations, especially if the intent is to allow the traditional small group market to exist alongside the portable group market. Modifying or applying state small group market regulations would only add an unnecessary layer of complexity. To avoid confusion, legislation should specifically provide that state small group market regulations do not apply.

*h.. COBRA Compliance*

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives certain former employees the right to continue health coverage at group rates for a temporary period of time. Many state laws expand on COBRA and, for instance, extend continuation health coverage to a broader set of former employees. When a former employee converts from portable group coverage to individual coverage they will maintain identical coverage at the same rate as before and for as long as they want to keep the coverage. This satisfies the main COBRA continuation health coverage requirements and goes one important step further by giving them long-term security in their coverage. However, there will be some additional bureaucratic details to include, such as guaranteeing employers give employees notice on how to convert coverage and giving employees some extra time to pay their first full premium. To give businesses clarity, it may be helpful for a state to legislate exactly how to convert portable group coverage to individual coverage in compliance with federal and state health coverage continuation requirements.

*i. Additional Protections against Double Dipping.*

While double dipping should not be allowed once coverage is defined as group coverage, it would be wise to include additional protections to guarantee it does not happen considering the coverage will be essentially the same product and purchased in the same pool as individual coverage.

*j. Minimum Contribution and Participation Requirements*

If an employee must pay the full insurance premium, a healthy employee will be less likely to enroll, which leaves a sicker pool of employees enrolling. To guard against this possibility, insurers and state small group market regulations have long imposed minimum participation and contribution requirements on employers to help guarantee enrollment by a broad mix of healthy



and sick employees. Though the ACA complicates the ability of insurers to impose these requirements, states should consider allowing insurers to apply minimum contribution and participation requirements in the portable group coverage market.

#### *k. Premium Billing and Payment Policies*

Billing and payments could become complicated when both employers and their employees are responsible for payment and payments are submitted individually for the individually-issued coverage. Mistakes could result in dropped coverage for employees. Ideally, insurers and employers will develop a simplified method of guaranteeing payment and consolidating billing. States should watch for whether billing and payment complications pose obstacles and, if they do, consider state policies that can help streamline the process.

#### *l. SHOP Exchange*

For states running their own exchange, consider offering portable group coverage through the SHOP exchange. Most state SHOP exchanges are failing to attract businesses. This is likely a reflection of the fact that exchanges unnecessarily duplicate services delivered by an insurance broker who employers deeply trust.<sup>75</sup> Also, the main reason to use the SHOP is to access tax credits, but the available tax credits apply to only a small number of employers and for only a limited time. With so few businesses using the SHOP, it turns out to be a very expensive government service considering the small number of businesses using it.

Transitioning the SHOP to provide individually-issued portable group coverage would allow the SHOP to more effectively piggy back on the infrastructure built to serve the individual market. It also creates the opportunity to give the employer a more hands off approach to administering health plans because the employer will know their employees have the same access to individualized services and support available to people in the individual market. This will likely be attractive to the smallest employers—the employers mostly likely to use SHOP. Very small employers are less likely to have worked with a broker before, keep employees for shorter terms and have fewer resources to administer a health plan.

#### *m. Employer Shared Responsibility Mandate*

A group health plan established to fund portable group coverage should satisfy the employer shared responsibility mandate so long as it meets the ACA's affordability and minimum value requirements.<sup>76</sup> To meet the affordability requirement, an employer will need to establish a method for setting contribution levels to make employee premiums affordable. For instance, an employer could set the contribution level as a percentage of a reference plan chosen by the

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<sup>75</sup> See LINDA J. BLUMBERG AND SHANNA RIFKIN, URBAN INSTITUTE, EARLY 2014 STAKEHOLDER EXPERIENCES WITH SMALL-BUSINESS MARKETPLACES IN EIGHT STATES 6 (August 2014) (“In the small business community, brokers and agents have long been employers’ trusted partners, educating and connecting small-employer groups to health coverage and other forms of insurance and services. ... As one informant noted, “one of the main reasons that SHOP enrollment is low is because small businesses trust their brokers, and brokers have been steering people away from the SHOP.”)

<sup>76</sup> PPACA § 1401(a), 26 U.S. Code § 36B(c)(2)(C).

employer, which is how most state-based SHOP exchanges function.<sup>77</sup> Any plan currently offered in a metal level tier on the individual market will satisfy minimum value, but catastrophic plans may not.<sup>78</sup>

#### *n. Permanent Risk Adjustment*

The ACA also includes a permanent risk adjustment program to redistribute money from insurers with low actuarial risks to insurers with high actuarial risks. The ACA requires this risk adjustment for coverage in the individual and small group market. Because portable group coverage and individual coverage will be part of the same pool, they should be part of the same risk adjustment program. States that wish to extend the portable group market to large employers should specifically state they are allowing large groups to join the risk adjustment program.

#### *o. Transitional Reinsurance Program Funding*

The ACA includes a temporary transitional reinsurance program to help stabilize premiums in the individual market. This program collects money from group health plans and redistributes it to fund high risk individuals in the individual market. This reinsurance program runs through the end of 2016. Because portable group coverage is an integrated component of a group health plan, any state implementing portable group coverage prior to the termination of the reinsurance program will need to make sure portable group coverage funds the program and does not receive individual coverage reinsurance payments. This issue will be moot for states implementing portable group coverage in 2017 and beyond when the reinsurance program is over.

Benefits administrators will develop product services to help employers establish compliant plans. However, to give employers confidence, there may still be a role for the state in defining the minimum steps an employer must take to satisfy the employer mandate.

### 4. Possible Challenges

Any change to the regulatory structure of the insurance market presents risks and challenges. Look no further than the current roll out of the ACA. Introducing a new category of group coverage that merges elements of group and individual market regulation will be no exception. In particular, adopting portable group coverage could impact risk selection in the individual and traditional group pools. Furthermore, despite efforts to address federal concerns, the federal government may still question a state's authority to establish portable group coverage. Any effort to adopt portable group coverage must be mindful of these challenges and be prepared to make adjustments along the way.

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<sup>77</sup> Sarah Dash and Kevin W. Lucia, *Employee Choice*, HEALTHAFFAIRS HEALTH POLICY BRIEF (September 18, 2014), available at [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_125.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_125.pdf).

<sup>78</sup> Federal regulations clarify that if a plan in the small group market meets the levels of coverage required by the metal tiers, then it meets the minimum value requirement. 45 CFR § 156.145(a)(4). The same should be true for portable group coverage because it will offer the same level of coverage.

### *a. Adverse Selection*

Adverse selection occurs in insurance markets “whenever people make insurance purchasing decisions based on their own knowledge of their insurability or likelihood of making a claim on the insurance coverage in question.”<sup>79</sup> In the health insurance market adverse selection occurs when individuals and businesses select or choose not to select a particular health plan, health insurer or health insurance market based on what they know about their health risk. Because people do know about their health and risk of making a claim, adverse selection poses a particular problem for health insurance markets.<sup>80</sup>

The main problem with adverse selection is that it reduces risk spreading within health insurance pools. Instead of having a broad mix of sick and healthy people, an insurance pool can get weighted with sicker, more expensive people which drives up premiums. This segmentation happens because sicker people tend to be attracted to more generous health plans, while healthier people tend to opt for more barebones coverage or no coverage at all. At the extreme, not enough healthy people in a given insurance pool can lead the pool into a “death spiral” where insurance rates spiral so high that no one can afford them. As the National Association of Insurance Commissioners explain: “It is imperative to minimize adverse selection in order for health insurance to remain a financially viable product.”<sup>81</sup>

Creating a portable group coverage market alters the structure of the insurance market and changes the choices available to individuals and businesses. Any change like this carries potential to minimize or aggravate adverse selection. For instance, allowing a portable group coverage market to exist alongside the traditional small group market would give small businesses a new choice to opt out of the small group market. Adverse selection could be aggravated if this choice is based on the risk profile of the group. Also, a portable group market will increase an employee’s choices for health plans, which will give employees more opportunities to choose a health plan based on their health status. This expanded choice could also incentivize insurers to develop health plan choices that attract healthy people and deter the sick.<sup>82</sup>

However, portable group coverage could also minimize adverse selection by reducing the present incentive for employers with healthy employees to self-insure. The simplified administration, cost stability, expanded choice and added security available through a defined contribution health plan may override any risk-based reason to self-insure. If the traditional small group market remains and employers opt for the new portable group market, there will still likely be a long-term benefit to retaining employers with healthier employees in the merged insurance pool versus them abandoning the insurance market altogether. Given the choice, better to broaden risk spreading in the individual insurance pool than to narrow it by shifting healthy people into self-insured arrangements.

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<sup>79</sup> NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT 1 (2011), available at <http://www.naic.org/store/free/ASE-OP.pdf>.

<sup>80</sup> David Cutler, *Public Policy for Health Care*, NBER WORKING PAPER SERIES, WORKING PAPER 5591 (May 1996), available at <http://www.nber.org/papers/w5591.pdf>.

<sup>81</sup> National Association of Insurance Commissioners *supra note* 79 at 1.

<sup>82</sup> *See id.* at 2.

In addition, adverse selection may be minimized if a portable group market encourages more small employers to offer health coverage. The additional financial assistance from both the employer contribution and the tax exclusion should encourage more people to gain insurance through the merged pool, people who might otherwise have felt healthy enough to remain uncovered.

There's no way to know for sure how a portable group market will impact adverse selection. It may be quite different from one state to another considering the risk profiles and market size of the individual and group markets can vary substantially. So, any state implementing portable group coverage must be alert to possible problems.

#### *b. Questions Over State Authority*

At its core, a portable group coverage market is a merger of the individual and group market. Under the ACA, states “may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.”<sup>83</sup> A portable group market should, therefore, be in compliance with the ACA so long as it is a valid exercise of a state's power to merge markets. The ACA, however, does not define merged market or provide further direction on how states may merge their markets. Federal regulations don't provide much more guidance.<sup>84</sup> This lack of direction creates uncertainty around how a state can properly merge insurance markets into a portable group market.

#### *i. ACA Allows Immediate Merger to Single Portable Group Market Risk Pool*

At a minimum, the ACA's market merger provision allows a state to merge the entire small group and individual markets into one portable group market and one risk pool in which both individuals and small employers buy individual insurance coverage. At the time Congress was debating the ACA, the American Academy of Actuaries issued a report on “whether legislation should include the merger of the individual and small group health insurance markets.”<sup>85</sup> They identified two basic merger approaches:

the first maintains an employer-based market structure and merges in individuals by treating them as “groups of one;” the second removes small groups below a specified size from the employer-based market and merges them into a reformed individual health insurance market.<sup>86</sup>

Lacking a definition of a merged market in the ACA, this description provides the best evidence for what Congress had in mind. Significantly, the second approach to a merged market creates the basic structure for a portable group market outlined above. Thus, there should not be any legal questions over a state's authority to take this approach.

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<sup>83</sup> PPACA § 1312(c)(3), 42 U.S. Code § 18032(c)(3).

<sup>84</sup> 45 CFR § 156.80

<sup>85</sup> See American Academy of Actuaries *supra note* 42.

<sup>86</sup> *Id.*

## ii. Merger Allowing Two Risk Pools Presents Legal Questions

Legal questions do begin to surface, however, if a state wants to take a more limited, gradual or phased approach to merging the markets. Immediately merging *two* markets into *one* market could cause substantial disruption. One of the two risk pools will likely be less healthy and, therefore, more expensive than the other. An immediate merger into a single risk pool would result in immediate rate hikes for the healthier pool. It might also require the cancelation of all of the policies from the pool being shut down and, as a result, force everyone with a canceled policy to shop for new coverage all at the same time. To avoid too much disruption, a state may want to start out by giving small employers the option to merge into the portable group market or continue offering traditional small group market coverage. Two risk pools would remain under this approach.

Whether a state can merge markets and allow two risk pools to remain is not clear under the law. The ACA's market merger provision is a component of the law's single risk pool requirement and so they must be understood together. The ACA requires insurers "to maintain a single state-wide risk pool for the individual market and single state-wide risk pool for the small group market."<sup>87</sup> Immediately following this requirement, the ACA then allows states to require the individual and small group markets to be merged. A state's flexibility in merging markets depends on whether the merged market provision is read as a clarification or read as an exception to the single risk pool requirement.

The merged market provision can be read as a clarification that the single risk pool requirement does not require separate risk pools for the individual and small group market. The word *single* means "only one" and with that meaning it operates as a restriction against insurers operating *multiple* pools within the same market.<sup>88</sup> With this meaning, the ACA's merged market provision is unnecessary to allow states to merge individual and small group markets into a single pool. Such a merger would continue to protect people from multiple pools. However, in addition to meaning "only one," single can also mean "separate." With that meaning, the single risk pool requirement would require the maintenance of separate risk pools for the individual and

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<sup>87</sup> News Release, U.S. Dep't of Health and Human Services, *Health care law protects consumers against worst insurance practices*, February 22, 2013, available at <http://www.hhs.gov/news/press/2013pres/02/20130222a.html>. Coverage purchased in the merged pool would likely still be defined by federal law as "small group market" coverage or "individual market" coverage based on whether or not the coverage is purchased in connection with a group health plan, regardless of how the state defines it. This would be similar to the case of "mixed" association health plans that are subject to individual, small group and large group market rules depending on the particular circumstances of each member. *See supra* note 34 to 35. If coverage purchased in the merged pool is still defined as individual and small group, then allowing a pool to coexist would result in two individual market pools or two small group market pools, depending on which remained. Why did Congress require a single risk pool? The single risk pool requirement is a subset of "consumer choice" protections included in the ACA to guard insurance consumers—buying coverage both inside and outside the Exchange—against possible problems related to introducing the Exchange. It protects consumers by prohibiting insurance companies from charging "higher premiums to higher cost enrollees by moving them into separate risk pools." In doing so, it helps guarantee more consumer choice within the Exchanges because there is no benefit to segmenting and limiting the type of products insurance companies offer in the Exchange when it's all in the same pool.

<sup>88</sup> Merriam-Webster Dictionary, <http://www.merriam-webster.com/dictionary/single> (accessed November 24, 2015) and Oxford Dictionaries, [http://www.oxforddictionaries.com/us/definition/american\\_english/single](http://www.oxforddictionaries.com/us/definition/american_english/single) (accessed November 24, 2015).

small group market. Congress may have simply included the merged market provision to clarify they did not intend to require separate risk pools and markets.

However, the merged market provision can also be read as an exception to the single risk pool requirement. With merged market text included under the single risk pool heading and immediately following the single risk pool requirement, it is reasonable to conclude the text is meant to modify the requirement. At the time the ACA passed, merging insurance markets was a well-known and significant policy tool under consideration at the state level. Because each state's insurance market faced unique challenges, there were widely varying approaches and goals to merging markets.<sup>89</sup> Understanding the significance, variations and possible disruptions of a merger, it's reasonable to conclude Congress intended to give states broad flexibility to merge their markets and recognized how state flexibility could be undermined by the single risk pool requirement. In other words, a merged market is a big idea and Congress wanted to make sure states could pursue it. Thus, they included the merged market provision as a limited exception to the single risk pool requirement.

The absence of federal oversight and lack of definition in the merged market provision further suggests Congress wanted to leave the details to the states. Unlike other ACA provisions, the ACA does not require states to receive federal approval to merge markets. Federal regulation only requires states to inform CMS of their decision to merge markets.<sup>90</sup> With no specific provision for federal oversight and no direction over how to merge markets, Congress likely intended to leave states with the power to decide how to merge their markets. This would be consistent with the ACA's repeated guarantee that states retain the power to regulate insurance.

Federal regulations provide that a state "may require the individual and small group insurance markets within a state to be merged into a *single risk pool*." This does suggest the federal government envisions only one risk pool will remain after a merger. Nonetheless, there can still be single risk pool for a merged market without closing down the risk pool for the traditional individual or small group market.

Neither reading of the text is satisfying. If Congress intended to clarify or provide an exception, they could have drafted much clearer language. Instead, Congress dropped a sentence referencing a major policy tool into the single risk pool section of the ACA with no additional

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<sup>89</sup> Consider these examples that all predate the passage of the ACA. Massachusetts merged their markets because the individual market was at the bottom of a death spiral. Kavita Patel and John McDonough, *From Massachusetts To 1600 Pennsylvania Avenue: Aboard The Health Reform Express*, 29 HEALTH AFFAIRS 1106 (June 2010), available at <http://content.healthaffairs.org/content/29/6/1106.full>. It was an immediate and quick fix. Minnesota considered "blending" markets as a way to expand choice for small business employees, allow continuous and portable coverage for individuals as job status changes, and provide larger pool to support an insurance exchange operations. DEBORAH CHOLLET, ET AL., MATHEMATICA POLICY RESEARCH, FINAL REPORT: HEALTH INSURANCE EXCHANGE STUDY (March 27, 2008), available at <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/mathematicafinalreport.pdf> Recognizing the disruptive nature of a merger, Vermont considered a phased merger that reduced premium variations over three years. ELLIOT K. WICKS, HEALTH MANAGEMENT ASSOCIATES, MERGING THE INDIVIDUAL, SMALL-GROUP, AND ASSOCIATION MARKETS IN VERMONT (January 2009), available at <http://www.leg.state.vt.us/CommissiononHealthCareReform/VT%20Merger%20Final%20Report%201-09.pdf>.

<sup>90</sup> 45 CFR 156.80 (c).

guidance and definition. As Chief Justice John Roberts pointed out in *King v. Burwell*, “The Affordable Care Act contains more than a few examples of inartful drafting.”<sup>91</sup> This is certainly one example.

Because it’s not clearly barred, a state should be able to take a more limited approach to a merged market, which avoids the disruption of shutting down a pool and cancelling policies. The federal government may push back or the federal government may acknowledge that state regulators are in a better position to weigh the disruption of closing down a pool against the risk selection dangers in maintaining two pools.

### iii. State Innovation Waiver

The federal government may conclude current law does not allow states to pursue certain strategies to create portable group coverage. In particular, the federal government may oppose allowing small employers to choose between two pools, a merged pool and traditional group pool. Though, there may be opposition to other approaches as well. To the extent the federal government concludes current law forecloses any strategy to create portable group coverage, a state will always have the option to request a state innovation waiver from the requirements of the law.

Section 1332 of the ACA allows states to request a waiver from certain requirements so long as the state meets certain standards.<sup>92</sup> Nearly every aspect of creating portable group coverage falls under an ACA requirement that can be waived through a state innovation waiver. This includes the single risk pool requirement, the definition of employer size, the definition of insurance market, the employer mandate, the individual mandate, the insurance exchange, tax credits, and benefit packages.

## IV. CONCLUSION

Uwe Reinhardt, an economics professor at Princeton, once wrote, “Ask any group of health policy experts whether they would have put in place our employment-based health insurance system, had they had the luxury of designing our health system from scratch, the resounding answer most likely would be ‘No.’”<sup>93</sup> Many, many employers and their employees would agree. According to Reinhardt, employer-based health insurance suffers from at least three shortcomings: costs are not transparent, plans are not portable and employee costs are tied to health of their colleagues.<sup>94</sup> Based on these and plenty of other issues with traditional employer-sponsored insurance, many employers would welcome the opportunity to shift to a new type of health plan—a defined contribution health plan where the employer helps their employees choose and buy portable health plans on the individual market.

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<sup>91</sup> *King v. Burwell*, 576 U.S. \_\_\_\_ (2015), available at [http://www.supremecourt.gov/opinions/14pdf/14-114\\_qol1.pdf](http://www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf).

<sup>92</sup> PPACA § 1332, 42 U.S. Code § 18052.

<sup>93</sup> Uwe E. Reinhardt, *Is Employer-Based Health Insurance Worth Saving?*, N. Y. TIMES ECONOMIX BLOG (May 22, 2009), available at [http://economix.blogs.nytimes.com/2009/05/22/is-employer-based-health-insurance-worth-saving/?\\_r=0](http://economix.blogs.nytimes.com/2009/05/22/is-employer-based-health-insurance-worth-saving/?_r=0).

<sup>94</sup> *Id.*

The passage of the ACA appeared to remove the major barriers blocking employers from offering a defined contribution health plan. Yet the Obama administration is now trying to bar these health plans and they are doing so without any clear legal authority. As a result, the Obama administration invites yet another legal challenge to the ACA. Instead of filing a lawsuit, states can also consider a less confrontational and more collaborative approach to allow employers to fund individual coverage that addresses the federal governments concerns.

While the Obama administration may have some legitimate policy concerns over allowing employers to fund individual coverage, the policy concerns are just that, concerns. No one knows exactly how the ACA will impact insurance markets. The fact is, the ACA set in motion a number of moving parts that pull low and high risk individuals and groups in different directions and there is no way to know what direction things will take. More employers, both small and large, subsidizing individual market policies could be just what the individual market needs to become more stable and competitive. To revive opportunities for employers to fund individual coverage without violating federal guidance, a state can create a new category of group coverage that blends, or merges elements of individual and group coverage.

If federal concerns do start turning into real problems, Congress wisely left states with the power and flexibility to regulate their insurance markets to address these problems. Indeed, in passing the ACA, Congress clearly intended to continue relying on states for solutions. A number of ACA provisions reiterate and reaffirm states' regulatory powers and roles. Compared to the federal government's blunt prohibition, states can offer more strategic solutions that mitigate risk selection problems while continuing to explore how employer funding can contribute to a more competitive individual market.