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How States Can Revive Defined Contribution Health Plans

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Key Points

- Many employers and their employees could benefit from a defined contribution health plan in which employers give employees a defined (fixed) pre-tax contribution to purchase individual market health coverage.
- The arrangment gives employees choice and ownership over a health plan they can keep when they leave their job. Employers gain better control over their health care spending. And both employees and the employer receive substantial savings because contributions are made pre-tax.
- The ACA appeared to expand opportunities for employers to offer these defined contribution health plans to their employees.
- Federal agencies, however, issued guidance in September 2013 which generally prohibits employers from making contributions to fund individual insurance coverage through a DC health plan.
- Though regulatory rulings issued by the federal government generally preempt, or preclude action by a state, there is an opportunity for states to change how they regulate and structure insurance markets to revive defined contribution health plans.
- States can create a new category of group insurance coverage called "portable group" coverage that can integrate with a defined contribution health plan and deliver the same choice, ownership, portability, and security as contributing to traditional individual coverage.

Introduction

Many employers would prefer to offer their employees a defined contribution health plan in which they give their employees a defined (fixed) monthly contribution to purchase individual market health coverage. The arrangement gives employers better control over their health care spending and gives employees choice and ownership over a health plan they can keep when they leave their job.

The passage of the Affordable Care Act (ACA) in 2010, according to legal scholars, appeared to clear away legal obstacles that had prevented employers from offering a defined contribution health plan to fund individual coverage in the past.

Federal agencies, however, issued guidance in September 2013 which prohibits employers from funding individual coverage on a pre-tax basis through a defined contribution health plan. The reason for the guidance is largely to fix a problem in the Affordable Care Act (ACA). As passed, the ACA allows an employer to set up a health plan that double dips on tax advantages available to employer contributions and tax credits available to individuals in the exchange. The guidance "fixes" this problem by effectively banning *all* employer contributions to individual market coverage both inside and outside the exchange. The ban covers both pre-tax and after-tax contributions.

Regulatory rulings issued by the federal government generally preempt, or preclude any action by a state government that conflicts with them. Consequently, a state clearly has no power to alter or override the federal guidance. So, at first blush it would appear there is nothing a state can do to respond to the federal action.

In this case, however, there is an opportunity for states to change how they regulate and structure health insurance markets in a way that (1) aligns with the federal guidance; (2) provides a legally sound fix to the problem of double-dipping on tax advantages; and (3) revives the opportunity for employers to offer tax-advantaged defined contribution health plans that connect employees with individual portable health coverage they can keep after they leave their job.

The rest of this report explains how the ACA opened up opportunities for defined contribution health plans, how the federal guidance effectively prohibits defined contribution health plans from funding individual market coverage, and how states can respond to revive opportunities for defined contribution health plans with a new type of coverage—"portable group coverage."

The ACA Opened New Opportunities for Defined Contribution Health Plans

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 (ESI) in the federal tax code. Health care costs paid by employers are excluded from income, providing substantial tax savings. Though employers could, in theory, fund individual market health coverage and take advantage of the tax exclusion, federal and state laws regulating employer health plans had made this impractical, if not impossible for most employers prior to the ACA.[1]

The main legal problem was that when an employer contributed to an individual market premium, the employer's health plan arrangement, in many cases, became a group health plan subject to group market regulations under federal law. 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

1 Revenue Ruling 61-146 held that individual insurance premiums paid by an employer are excluded from income under IRS Code Section 106 just like other health care costs. IRS Rev. Rul. 61-146, January 1, 1961, available at http://www.irs.gov/pub/irs-drop/rr-61-146.pdf. Despite this ruling, 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 rule that individual market premiums could be funded through Health Reimbursement Arrangements. IRS Notice 2002-45, 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. Internal Revenue Service, Internal Revenue Bulletin 2007-39 (September 24, 2007): Reg. § 1.125-1(m), available at http://www.irs.gov/irb/2007-39_IRB/ar14.html.

market regulations prohibited discrimination on health status. This incompatibility made it very difficult for employers to fund individual market premiums without violating federal group market regulations.

Effective January 1, 2014, the ACA eliminated the regulatory differences between group and individual market coverage that had made funding individual market premiums with employer contributions so difficult. Thus, by eliminating these regulatory differences, the ACA opened the door to funding individual market premiums through a defined contribution health plan. Law professors Mark Hall and Amy Monahan, who have studied these issues quite closely in recent years, reach the same conclusion. They explain,

> 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 [federal law]. [2]

Federal Guidance Closes the Door

Though the ACA provisions outlined above appear to allow employers to pay individual market premiums pre-tax, federal guidance issued by the Departments of Treasury and Labor in September 2013 effectively bans the practice.[3]

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 to pay individual market premiums.

More specifically and technically speaking, regulators are asserting that the written plan documents of a group health plan providing for the payment of health care—e.g., a health reimbursement arrangement and cafeteria plan—cannot be *integrated* with individual market insurance coverage to satisfy the annual dollar limit prohibition and the preventive services requirements. A group health plan, however, can be integrated with group coverage for the purposes of the two requirements.

The end result: The guidance effectively prohibits any and all defined contribution health plans established to fund individual market coverage on a pre-tax basis. This is despite the fact that pre-tax funding of individual market coverage was legal prior to the passage of the ACA. The Joint Committee on Taxation of t he U.S. Congress makes this point very clearly in their technical explanation of the ACA. When describing federal law at the time the ACA passed, they state, "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."[4]

To the extent the guidance left any questions open, federal agencies have attempted to clarify the ban on employers contributing to individual market premiums on three separate occasions, the most recent being an IRS Notice issued in February 2015.[5]

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2 Mark A. Hall and Amy B. Monahan, "Paying for Individual Health Insurance Through Tax-Sheltered Cafeteria Plans," *Inquiry*, Vol. 47 (Fall 2010): 252-61.

3 Internal Revenue Service, Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements, Notice 2013-54, available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf; and United States Department of Labor, "Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements," Technical Release No. 2013-03 (September 13, 2013), available at http://www.dol.gov/ebsa/newsroom/tr13-03.html.

4 Joint Committee on Taxation, U.S. Congress, *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.

5 IRS Notice 2015-17, 2015-14 I.R.B. 845, available at https://www.irs.gov/pub/irs-drop/n-15-17.pdf; U.S. Depepartment of Labor, FAQs about Affordable Care Act Implementation (Part XXII), November 6, 2014, http://www.dol.gov/ebsa/faqs/faq-aca22.html; Centers for Medicare and Medicaid Services, FAQs about Affordable Care Act Implementation (Part XXII), November 6, 2014, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-

Thus, two health plan requirement have effectively changed the tax treatment of employer contributions to individual market coverage, not any change to the tax code. This is an important point because it underlies the ability of a state to respond to this change in the tax treatment of employer contributions to health coverage—something a state would generally have no power to address. While states have no power over the federal tax code, they do retain some power to regulate insurance.

The legal basis for the holding in the guidance is hard to understand. The main problem with the holding is that the two requirements apply to both the individual and group markets. 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 the individual market. Without an explanation, there's no convincing legal authority to ban employers from funding individual market coverage with pre-tax dollars. And without legal authority, there's a substantial chance federal agencies would lose any legal challenge to their actions.[6]

The policy basis is much, much easier to understand. While the Obama administration has not directly expressed their policy concerns, they did identify two concerns in private talks with the U.S. Chamber of Commerce, according to a letter the U.S. Chamber sent to the Obama administration. 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."[7]

Second, the administration is "concerned about double dipping, i.e., letting employees buy federally subsidized coverage on the exchanges with tax-free employer reimbursement."[8]

Both are legitimate concerns, but the concern over double dipping is likely the primary concern. The concern over risk selection is speculative and one that state regulators would be compelled to address if it truly became a problem. Allowing employers to double dip on tax advantages, however, could very quickly escalate the cost of the ACA to the federal budget. There would certainly be substantial political fallout and embarrassment if a drafting oversight in the ACA began adding hundreds of millions of dollars to the federal budget deficit.

Knowing the policy rationale for the guidance is very helpful in crafting a state response that the federal government will view as a constructive and collaborative effort to coordinate federal and state insurance regulations in addressing yet another ACA implementation challenge.

Federal Regulators Could Not Target a Solution to Solve Their Policy Problem

Federal regulators possibly wanted to take a more targeted approach to stop double dipping on tax advantages and to stop large groups from dumping high risk employees into the individual market. But

FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf; and Internal Revenue Service, "Employer Health Care Arrangments," at http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements, at http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements (first posted online in May 13, 2014 and last modified April 16, 2015).

6 For a complete discussion on the lack of legal authority to issue the guidance, *see* Peter J. Nelson, "State Strategies to Revive Defined Contribution Health Plan Options in Response to New Federal Obstacles," Center of the American Experiment Working Paper (December 8, 2015), available at http://www.americanexperiment.org/publications/reports-books/working-paper-state-strategies-to-revive-defined-contribution-health-plan.

7 Randel K. Johnson and Katie Mahoney, U.S. Chamber of Commerce letter, 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.

8 *Id*. Here's how double dipping can work due to an oversight in drafting the ACA. 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 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 use tax credits in the exchange and then use their employer account to pay any remaining premium with pre-tax dollars.

there was no direct approach available. The latest IRS Notice admits the tax exclusion for individual market premiums still exists.[9] And nothing in the ACA directly prohibits employers from funding individual market premiums.
Without any clear and direct change to the tax exclusion or employer options to offer defined contribution health plans in the ACA, federal agencies took a more indirect approach and used seemingly unrelated insurance regulations—the annual dollar limit prohibition and the preventive services requirements—to achieve their goals.

Unfortunately, the lack of a targeted 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, all employers lost an important strategy for providing health coverage to their employees.

How States Can Revive Defined Contribution Health Plans

While limits 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 individually-issued coverage. Here's how to do it.

To begin, a state should create a new category of group coverage called "portable group coverage." Alternatively, a state could call it defined contribution group coverage, merged market coverage or whatever it chooses. This new category of coverage should be defined as insurance coverage purchased in the traditional individual market using *any* employer funds. States should then require the new coverage to meet both state indivividual market regulations and federal group market regulations. In doing so, the individually-issued coverage funded by the employer becomes group coverage subject to federal group coverage regulation.

Once defined as group coverage under federal law, two important things happen. First, as group 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."[10] This then delivers the alternative, targeted solution to eliminate the double-dipping problem.

Second, as group 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 defined contribution health plan to fund *individualized* coverage and satisfy the requirements of the federal guidance.

Though subject to group coverage regulations, portable group coverage would remain *individualized* and share the same risk pool and product lines as traditional individual coverage. Thus, this would be a "merged market." It's not individual market coverage, but rather individually-issued portable group market coverage.

While this might seem to be an odd arrangement, the ACA clearly envisions states may want to merge the individual and small group market risk pools at some point.[11] This is one type of merger and because it "does not prevent the application" of any provision of the ACA, the state should maintain regulatory authority to do so.[12]

9 *See* IRS Notice 2015-17 *supra note* 5.

10 PPACA § 1401, 26 U.S. Code § 36B.

11 PPACA § 1312(c)(3), 42 U.S. Code § 18032(c)(3).

12 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.

As stated above, portable group coverage in the merged market will need to meet group coverage requirements under federal law. With the repeal of the ACA's annual deductible limits for small group coverage in the Protecting Access to Medicare Act of 2014, there is virtually no difference in how individual and small group plans are regulated at the federal level.[13] The only substantial difference is between the enrollment period restrictions, but, as explained further on, this difference can be addressed. Federal large group requirements do not pose an issue because they are less restrictive and, therefore, do not add anything.

Here are key issues and options state lawmakers should consider.

- **Limiting portable group coverage to small employers.** Though states should have the power to allow large employers to participate in a portable group market, a state may wish to limit portable group coverage to small employers if it shares the Obama administration's concern that a disproportionate number of large employers with sicker-than-average employees will leave the large group market.
- **Retain the traditional small group market and pool.** Efforts to merge markets into a portable group market will likely start with merging the individual and small group market. To do so, one option is to immediately merge the two markets into one market and one risk pool. However, this could cause substantial market disruption. It would require shutting down the traditional small group market and risk pool, which will likely lead to immediate premium increases in the individual or small group market, depending on which market holds a sicker population. It might also require the cancelation of all small group policies 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 retain the traditional small group market and pool when it merges individuals and small employers into a portable 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, allowing the small group pool to remain is subject to some legal uncertainties that can be avoided by closing the pool. Not closing the traditional small group market leaves portable group coverage open to the argument that it creates two small group market risk pools in violation of the ACA's single risk pool provision.[14] Additionally, leaving the small group pool open may create more opportunity for adverse risk selection because it gives small employers another option to select.
- **Automatic conversion from portable group coverage to individual coverage.** State regulation should be clear that group coverage converts to individual coverage when the employer stops funding the coverage and vice versa. This will guarantee portable coverage for people as they change employment status.
- **COBRA and state continuation health coverage requirements.** Tied to automatic conversion, 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. 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

Code § 1144 (b)(2)(A).

13 If a state merges the individual and small group market, federal regulations implementing the SHOP exchange only cite 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 portable group coverage must meet on top of individual coverage requirements.

14 The ACA does not define how states can merge individual and small group markets. Nor do federal regulations. However, unlike the text of the ACA, the federal regulations reference a "single" merged risk pool. 45 CFR § 156.80(c). A partially merged risk pool would be a single risk pool, but it would leave a second small group market risk pool in place, which could be argued is a violation of the ACA's single risk pool provision. *See* Nelson *supra note* 6 at pages 28 to 31 for additional analysis.

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.

- **Enrollment period restrictions.** ACA regulations restrict people from enrolling in the individual market to an annual open enrollment period in order to guard against people waiting until they are sick to buy health insurance. In contrast, regulations require insurers to allow employers to purchase group coverage "at any point during the year."[15] 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. This would allow an employer to opt for portable coverage at any time throughout the year, but restrict new employees from gaming the system and waiting until they get sick to sign up for the employer's group health plan.
- **Minimum participation and contribution requirements.** A state will need to decide whether to apply or allow insurers to apply minimum participation and/or contribution requirements to the portable group coverage market. These requirements intend to help insurance companies avoid adverse selection, but there may be less need for such requirements if portable group coverage is subject to one open enrollment period.
- **Integration with the Small Business Health Options Program Exchange (SHOP exchange) and availability of small business tax credits.** A SHOP exchange could be structured to provide portable group coverage and connect small employers with small business tax credits. Currently, very few employers are using a SHOP exchange. Integrating portable group coverage with the SHOP exchange would make it more attractive by giving employees far more choice in health plans and guaranteeing portability.

In May 2015, Minnesota legislators in the House and the Senate introduced bills to create portable group coverage, which the respective bills called "merged market coverage."[16] These Minnesota proposals provide a model for other state lawmakers to follow that address most of the issues just outlined. But states will need to consider many other details, which are outlined in a Working Paper on the topic published by Center of the American Experiment.[17]

If a portable group market is carefully structured to address the federal government's concerns, then there's a reasonable chance the federal government will welcome it as a constructive and collaborative effort. However, federal agencies can certainly object and claim portable group coverage still violates some provision in the ACA, such as the single risk pool requirement. But to do so, the federal government will at that point need to preempt a specific state law, which becomes a weightier matter.

Conclusion

Though the ACA appeared to expand opportunities for employers to offer defined contribution health plans to their employees, federal guidance recently foreclosed all avenues to use employer funding to pay for individual market premiums. This eliminates a very promising type of group health plan that would empower employees with more choice and allow them to own a portable health plan they could keep as their job status changes. States, however, can respond in a way that both addresses the policy concerns of the federal government and revives opportunities for tax-advantaged defined contribution health plans. To do so, states should follow the steps outlined here to create a new category of portable group health coverage that can integrate with a defined contribution health plan and deliver the same choice, ownership, portability, and security as before. ■

15 45 CFR § 147.104(b)(1). Note this regulation appears to violate the plain text of the ACA. According to the ACA, "A health insurance issuer … *may* restrict enrollment in coverage … to open or special enrollment periods" (emphasis added). PPACA § 2702(b)(1), 42 U.S. Code § 300gg-1(b)(1). By requiring insurers to sell group coverage to an employer "at any point during the year" the regulations strike the permission the ACA gives to insurers and state insurance regulators to restrict enrollment to certain periods.

16 Minn. S.F. 3172, 89th Legislature 2015-2016; and Minn. H.F. 2332, 89th Legislature 2015-2016.

17 Nelson *supra note* 6, pp. 22-26.

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