

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 37



U.S. Department of Labor
Employee Benefits Security Administration
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Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at www.dol.gov/ebsa/healthreform/index.html and www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the law and benefit from it, as intended.

HEALTH REIMBURSEMENT ARRANGEMENTS

On September 13, 2013, DOL published Technical Release 2013-03¹ addressing the application of the Affordable Care Act market reforms to health reimbursement arrangements (HRAs) and employer payment plans (EPPs).² The Treasury Department and the Internal Revenue Service (IRS) contemporaneously published parallel guidance in Notice 2013-54,³ and HHS issued guidance stating that it concurred in the application of the laws under its jurisdiction as set forth in the guidance issued by DOL, Treasury, and IRS.⁴ Subsequent guidance reiterated and clarified the application of the market reforms to HRAs and EPPs.⁵

EPPs and HRAs typically consist of an arrangement under which an employer reimburses medical expenses (whether in the form of direct payments or reimbursements for premiums or other medical costs) up to a certain dollar amount. As explained in Technical Release 2013-03 and Notice 2013-54,

¹ Technical Release 2013-03 is available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>.

² Section 1001 of the Affordable Care Act added new Public Health Service Act (PHS Act) sections 2711-2719. Section 1563 of the Affordable Care Act (as amended by Affordable Care Act section 10107(b)) added Internal Revenue Code (Code) section 9815(a) and Employee Retirement Income Security Act (ERISA) section 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

³ 2013-40 IRB 287. Notice 2013-54 is available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>.

⁴ See Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>.

⁵ There have been several issuances on the topics addressed in the 2013 guidance: (1) FAQs About Affordable Care Act Implementation (Part XI), issued on January 24, 2013 by DOL (<http://www.dol.gov/ebsa/faqs/faq-aca11.html>) and HHS (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html); (2) IRS Notice 2013-54 and DOL Technical Release 2013-03, issued on September 13, 2013; (3) IRS FAQ on Employer Healthcare Arrangements (<http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements>); (4) FAQs About Affordable Care Act Implementation (Part XXII), issued on November 6, 2014 by DOL (<http://www.dol.gov/ebsa/faqs/faq-aca22.html>) and HHS (<http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>); (5) Notice 2015-17, 2015-14 IRB 845, issued by Treasury and IRS on February 18, 2015; and (6) Notice 2015-87, 2015-52 IRB 889, Q&A-1 to Q&A-6, issued by Treasury and IRS on December 16, 2015. See also 26 CFR 54.9815-2711(d), 29 CFR 2590.715-2711(d), and 45 CFR 147.126(d) (80 FR 72192, Nov. 18, 2015).

and except as provided in the 21st Century Cures Act with respect to Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs),⁶ EPPs and HRAs are group health plans that are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual dollar limits under PHS Act section 2711 and the requirement to provide coverage of certain preventive services without cost sharing under PHS Act section 2713. The 2013 guidance generally provides that EPPs and HRAs will fail to comply with these group market reform requirements because these arrangements, by definition, reimburse or pay medical expenses on the employee's behalf only up to a certain dollar amount each year; those rules do not apply to QSEHRAs.

INTEGRATION OF HRAs WITH GROUP HEALTH PLANS SPONSORED BY THE EMPLOYER OF A SPOUSE OF AN EMPLOYEE

The 2013 guidance provided that an HRA will not fail to meet the group market reform provisions of the Affordable Care Act when “integrated” with a group health plan that otherwise complies with those provisions under the integration methods described in that guidance. On November 18, 2015, the Departments issued final regulations implementing PHS Act section 2711, which incorporate the general rule set forth in the 2013 guidance clarifying that an HRA or EPP cannot be integrated with individual market policies to satisfy the market reforms.⁷

Specifically, Q&A-4 of Notice 2013-54 and Technical Release 2013-03 provides requirements for integrating an HRA with a group health plan. Under Q&A-4, integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor. An example in Q&A-4 illustrates that an HRA for an employee may be integrated with a non-HRA group health plan sponsored by the employer of the employee's spouse.⁸

Subsequently, the Treasury Department and the IRS issued Notice 2015-87. Q&A-4 of Notice 2015-87 clarifies that an HRA available to reimburse the medical expenses of an employee's spouse and/or dependents (a family HRA) may not be integrated with self-only coverage under the employer's other group health plan. Questions have arisen regarding the application of Q&A-4 of Notice 2015-87 to a family HRA in cases in which the employee is enrolled in self-only coverage and the employee's spouse and dependents are enrolled in a non-HRA group health plan sponsored by the spouse's employer.

Q1: MAY A FAMILY HRA BE INTEGRATED WITH A NON-HRA GROUP HEALTH PLAN SPONSORED BY THE EMPLOYER OF THE EMPLOYEE'S SPOUSE THAT COVERS ALL OF THE INDIVIDUALS COVERED BY THE FAMILY HRA IF THAT NON-HRA GROUP HEALTH PLAN OTHERWISE MEETS THE APPLICABLE INTEGRATION REQUIREMENTS?

Yes. For purposes of determining whether a family HRA is “integrated” with a non-HRA group health plan, an employer may rely on the reasonable representation of an employee that the employee and other individuals covered by the family HRA are also covered by another non-HRA group health plan

⁶ See FAQs About Affordable Care Act Implementation (Part 35), Q&A-3, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-35_12-20-16.pdf.

⁷ 26 CFR 54.9815-2711(d), 29 CFR 2590.715-2711(d), and 45 CFR 147.126(d); see also 80 FR 72192, Nov. 18, 2015.

⁸ This rule is repeated in 26 CFR 54.9815-2711(d)(2), 29 CFR 2590.715-2711(d)(2), and 45 CFR 147.126(d)(2).

that otherwise meets the applicable integration requirements (a qualifying non-HRA group health plan).

Q2: MAY A FAMILY HRA BE INTEGRATED WITH A COMBINATION OF (1) SELF-ONLY COVERAGE OF THE EMPLOYEE BY A QUALIFYING NON-HRA GROUP HEALTH PLAN SPONSORED BY THE EMPLOYER AND (2) QUALIFYING NON-HRA GROUP HEALTH PLAN COVERAGE SPONSORED BY THE EMPLOYER OF THE EMPLOYEE’S SPOUSE THAT COVERS ALL MEMBERS OF THE FAMILY COVERED BY THE FAMILY HRA (OTHER THAN THE EMPLOYEE)?

Yes. A family HRA is permitted to be integrated with a combination of coverage under other qualifying non-HRA group health plans for purposes of the group market reforms, provided that all of the individuals who are covered under the family HRA are also covered under other qualifying non-HRA group health plan coverage. The integration rules do not require that the HRA and the non-HRA group health plan with which it is integrated share the same plan sponsor, or that all of the individuals are covered under the same non-HRA group health plan, provided that all of the individuals covered by the HRA are also enrolled in other qualifying non-HRA group health plan coverage. For example, a family HRA covering an employee, spouse, and one dependent child may be integrated with the combination of (1) the employee’s self-only coverage under the non-HRA group health plan of the employee’s employer, and (2) the spouse and dependent child’s coverage under the non-HRA group health plan of the spouse’s employer, provided that both non-HRA group health plans are qualifying non-HRA group health plans.

CODE SECTION 162(M)(6)

Code section 162(m)(6)(A), as added by the Affordable Care Act, generally imposes an annual \$500,000 limitation on an employer’s federal income tax deduction for applicable individual remuneration for any disqualified taxable year. Code section 162(m)(6)(B) defines a “disqualified taxable year,” with respect to any employer, as any taxable year for which the employer is a covered health insurance provider. Code section 162(m)(6)(C)(1) provides that the term “covered health insurance provider” means, with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in Code section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in Code section 9832(b)(1)) is from minimum essential coverage (as defined in Code section 5000A(f)).⁹

As discussed in further detail below, questions have arisen whether certain clinical risk-bearing entities are covered health insurance providers for purposes of Code section 162(m)(6) (and thus subject to the deduction limitations for payments of certain remuneration), which requires determining whether these entities are health insurance issuers that receive premiums from providing health insurance coverage that is minimum essential coverage.

Code section 9832(b)(2) (the definition of “health insurance issuer”) and Code section 9832(b)(1) (the definition of “health insurance coverage”) were added to the Code by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which simultaneously added parallel provisions at ERISA

⁹ Code section 162(m)(6)(C)(ii) further provides for aggregation rules, stating that two or more persons who are treated as a single employer under Code section 414(b), (c), (m), or (o) shall be treated as a single employer, except that in applying Code section 414(b) and (c), Code section 1563(a)(2) and (3) are disregarded.

section 733(b) and PHS Act section 2791(b). Under Code section 9832(b)(2), ERISA section 733(b)(2), and PHS Act section 2791(b)(2), the term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in Code section 9832(b)(3), ERISA section 733(b)(3), and PHS Act section 2791(b)(3)), which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of ERISA section 514(b)(2), as in effect on August 21, 1996), but the definition explicitly excludes a group health plan. In relevant part, Code section 9832(b)(1)(A), ERISA section 733(b)(1), and PHS Act section 2791(b)(1) provide that the term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

APPLICATION OF CODE SECTION 162(M)(6) TO CERTAIN CLINICAL RISK-BEARING ENTITIES

Since the regulations under Code section 162(m)(6) were issued, questions have arisen with respect to the application of Code section 162(m)(6) to entities that contract with the Centers for Medicare & Medicaid Services (CMS) to provide coverage as a clinical risk-bearing entity that is a licensed health insurer under State law in one or more of the following capacities: (1) as a Medicaid Managed Care Organization (MCO), within the meaning of Social Security Act (SSA) section 1903(m);¹⁰ (2) as a Medicare Advantage organization governed by SSA sections 1851-1859¹¹ and approved by CMS under the rules set forth at 42 CFR 422.503; or (3) as a Medicare Part D prescription drug plan.¹² These entities have asked for further clarification regarding whether they are providing health insurance coverage for purposes of Code section 162(m)(6) (and thus may be subject to the deduction limitations).

The final regulations do not address whether, for purposes of Code section 162(m)(6), a covered health insurance provider includes a clinical risk-bearing entity that is a licensed health insurer under State law providing services under certain types of arrangements as part of the Medicare and Medicaid programs. Section II.B of the preamble to the final regulations acknowledges that a person cannot be a covered health insurance provider unless it is a health insurance issuer that receives premiums from providing health insurance coverage, but the preamble explains that the definitions of the terms “health insurance issuer” and “health insurance coverage” have significant importance in many sections of the Code, ERISA, and the PHS Act, and that it would be inappropriate to provide broad guidance interpreting those terms in the regulations under Code section 162(m)(6), because that would require full consideration of the possible effects of that guidance on other statutory provisions.¹³ The preamble notes that future guidance may be provided on the meaning of those terms, including for purposes of the application of Code section 162(m)(6).

¹⁰ 42 U.S.C. 1396b(m).

¹¹ 42 U.S.C. 1395w-21 - 1395w-28.

¹² See section II.B. of the preamble to the section 162(m)(6) regulations, 79 FR 56892, 56895 (September 23, 2014).

¹³ 79 FR 56892, 56895.

MLR GUIDANCE PROVIDED IN CCIIO TECHNICAL GUIDANCE 2012-002

In 2012, CMS issued CCIIO Technical Guidance 2012-002 addressing whether insurance coverage provided under the Medicaid and Medicare programs is subject to the medical loss ratio (MLR) rules, added to Title XXVII of the PHS Act at section 2718, which require a health insurance issuer to issue a rebate to enrollees if the issuer's MLR is less than the applicable percentage.¹⁴ Q&A-24 addresses application of the MLR rules to benefits provided through an MCO contract with a State Medicaid agency. In the answer to Q&A-24, CMS concludes that because such coverage is governed by Title XIX of the SSA and underlying regulations and not by otherwise applicable State insurance law, issuers of the Medicaid coverage are offering neither group nor individual health insurance coverage and therefore are not subject to the MLR rules with respect to that coverage. CMS further notes that Congress recognized that PHS Act Title XXVII does not apply to MCO contracts when it enacted SSA section 1932(b)(8), which makes some, but not all, Title XXVII requirements applicable to MCO contracts.¹⁵

Similarly, Q&A-25 of CCIIO Technical Guidance 2012-002 addresses the application of the MLR rules to Medicare benefits provided by contract with CMS, such as Medicare Advantage plans (Medicare Part C) and Medicare prescription drug plans (Medicare Part D). CMS concludes that this coverage also is not group health insurance coverage as defined under PHS Act section 2791(b)(4) (because the coverage is primarily provided under a contract with the Medicare program) or individual health insurance coverage as defined under PHS Act section 2791(b)(5) (because the coverage is not offered to individuals in the individual market); rather, this coverage is subject to a comprehensive regulatory scheme under Parts C and D of Title XVIII of the SSA and regulations at 42 CFR Parts 422 and 423. In addition, CMS again notes that Congress recognized the inapplicability of PHS Act section 2718 to Medicare Advantage plans by adding separate and distinct MLR requirements to the Part C statute.

COORDINATED AND CONSISTENT INTERPRETATION OF “HEALTH INSURANCE COVERAGE”

Section 104 of HIPAA requires the Departments to interpret consistently the provisions shared by the Departments, including the definitions of “health insurance coverage” as used in the Code, ERISA, and the PHS Act. These FAQs have been prepared jointly by the Departments and are intended to provide a consistent interpretation and application of the term “health insurance coverage” to the specific arrangements identified in the following questions.

¹⁴ CCIIO Technical Guidance (CCIIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation (April 20, 2012), available at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-qna-04202012.pdf>.

¹⁵ SSA section 1932(b)(8) reflects an amendment made by the Budget Act of 1997. The amendment applied certain maternity and mental health parity requirements to MCOs. On November 13, 2013, the Departments finalized rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which imposes mental health and substance use disorder parity rules on health insurance issuers providing health insurance coverage and group health plans. 78 FR 68240. MHPAEA is codified in section 712 of ERISA, section 2726 of the PHS Act, and Code section 9812. In the preamble to the final MHPAEA rules, the Departments note that the final rule does not apply to MCOs although those entities are separately subject to mental health and substance use disorder parity requirements that “are incorporated by reference into statutory provisions that do apply to those entities.” 78 FR 68240, 68252. On March 30, 2016, CMS separately finalized a rule implementing the mental health and substance use disorder parity provisions applicable to MCOs under SSA section 1932(b)(8). 81 FR 18390.

Q3: DOES A CLINICAL RISK-BEARING ENTITY THAT IS A LICENSED HEALTH INSURER UNDER STATE LAW PROVIDE HEALTH INSURANCE COVERAGE WITHIN THE MEANING OF CODE SECTION 9832(B)(1), ERISA SECTION 733(B)(1), AND PHS ACT SECTION 2791(B)(1) WITH RESPECT TO ITS PROVISION OF MEDICAID COVERAGE TO MEDICAID RECIPIENTS AS AN MCO UNDER CONTRACT WITH A STATE AGENCY?

No. Notwithstanding that a clinical risk-bearing entity is a licensed health insurer under State law, the provision of Medicaid coverage to Medicaid recipients as an MCO is not the provision of health insurance coverage within the meaning of Code section 9832(b)(1), ERISA section 733(b)(1), and PHS Act section 2791(b)(1), because the coverage is governed by SSA Title XIX and underlying regulations and not by otherwise applicable State insurance law.¹⁶

Q4: DOES A CLINICAL RISK-BEARING ENTITY THAT IS A LICENSED HEALTH INSURER UNDER STATE LAW PROVIDE HEALTH INSURANCE COVERAGE WITHIN THE MEANING OF CODE SECTION 9832(B)(1), ERISA SECTION 733(B)(1), AND PHS ACT SECTION 2791(B)(1) WITH RESPECT TO ITS PROVISION OF COVERAGE UNDER A MEDICARE ADVANTAGE ORGANIZATION OR PLAN OR A MEDICARE PRESCRIPTION DRUG PLAN?

No. Notwithstanding that a clinical risk-bearing entity is a licensed health insurer under State law, the provision of coverage under a Medicare Advantage organization or plan or a Medicare prescription drug plan is not the provision of health insurance coverage within the meaning of Code section 9832(b)(1), ERISA section 733(b)(1), and PHS Act section 2791(b)(1), because the coverage provided by such an entity is governed by Parts C and D of SSA Title XVIII and regulations at 42 CFR Parts 422 and 423, rather than otherwise applicable State insurance law. This FAQ does not address the ERISA status of, or any obligations under ERISA with respect to, any such arrangement.

¹⁶ The same conclusion regarding treatment under Code section 9832(b)(1), ERISA section 733(b)(1), and PHS Act section 2791(b)(1) applies to Prepaid Ambulatory Health Plans and Prepaid Inpatient Health Plans provided to Medicaid and Children's Health Insurance Program enrollees governed by 42 CFR Part 438.