Health Care Reform and the Future of Health Reimbursement Arrangements

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Overview

As health plans renew in 2014, several Affordable Care Act (ACA) reform provisions go into effect. Some provisions affect a non-excepted health plan – which means a health plan that is subject to the HIPAA portability requirements, such as an employer's group medical plan and most health reimbursement arrangements (HRAs). Other provisions apply only if the plan is a non-grandfathered non-excepted health plan – which means that the non-excepted health plan has changed appreciably in coverage or employee share of premium since March 23, 2010. Finally, insured non-grandfathered non-excepted individual or small group market health plans are subject to specific limitations and coverage mandates.

For employers that currently provide an HRA to reimburse certain medical care expenses or for employers that are contemplating adoption of an HRA, the effect that the ACA provisions will have on that employer's health plan or the HRA have left some to wonder if HRAs have a future?

The purpose of this whitepaper is to explore several ACA reform provisions and the impact each provision has on an employer's health plan including the HRA. Through an understanding of the provisions, the future that an HRA can have after the provisions go into effect will be clearer.

No Annual or Lifetime Limit

As plans renew in 2014, all non-excepted health plans, whether insured or self-insured, are prohibited from placing a limit on the lifetime or annual reimbursement for covered eligible essential health benefit (EHB) expenses[1]. This means that the employer's medical plan cannot have a lifetime or annual maximum limit on EHBs, since the medical plan is a non-excepted benefit.

Excepted HRA

Excepted benefits, such as stand-alone dental or vision plans and retiree only health plans are not subject to this provision. HRAs that reimburse only dental or vision expenses or that cover only retirees are excepted benefit HRAs and not subject to this provision. These HRAs certainly have a future when the provision goes into effect in 2014.

Non-Excepted HRA

However, most HRAs are non-excepted benefits since the HRA reimburses medical expenses associated with the group medical plan or the HRA does not fit one of the excepted benefit designs; therefore, the HRA is major medical coverage in its own right. Since almost all HRAs have a limit to the amount that a participant has available for reimbursement from the employer's funds, the issue is whether a non-excepted HRA can continue to have a limit.

[1] Federal Register, June26, 2010

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Integrated HRA

Guidance from the regulators permits an HRA that is integrated with an employer's non-excepted medical plan to continue to have a limited benefit amount since the medical plan the HRA is integrated with must provide the unlimited benefit amount[2]. The guidance defines an integrated HRA as an HRA that covers the participant because the participant is enrolled in the employer's group non-excepted medical plan.

In addition, the regulators allow an employer to integrate its HRA with the non-HRA coverage an employee is enrolled in through another employer, such as the employee's spouse[3]. In the guidance, an employer is allowed to integrate its HRA with another employer's non-HRA group medical coverage and designing its HRA to take into account the minimum value of the other plan or by disregarding the minimum value of the other plan.

Therefore, employers that have designed their HRAs to reimburse medical expenses only for employees who are enrolled in the employer's group health plan or are enrolled in another employer's group medical plan have integrated HRAs and those HRAs are not subject to the no annual or lifetime limit provision. These integrated HRAs certainly have a future when the provision goes into effect in 2014.

Non-Integrated HRA

On the other hand, a non-excepted, non-integrated HRA is subject to the no annual or lifetime benefit amount provision[4]. For example, an HRA that reimburses any eligible medical care expenses (e.g., an all Section 213(d) HRA) for employees who work 30 hours per week or more regardless of enrollment in an employer's group medical plan is a non-integrated HRA. When that HRA renews in 2014, the employer cannot limit the annual or lifetime amount of reimbursement from the HRA for those medical care expenses. It is unlikely that an employer with this type of HRA will continue this plan design when the provision goes into effect.

Premium Only HRA

Some non-integrated HRAs are designed to reimburse individual insurance plan premiums only. If this premium-only HRA is a retiree-only HRA, then the plan is an excepted benefit and not subject to the provision.

However, premium-only HRAs for active employees are subject to this provision. The regulatory guidance that allows integrated HRAs to continue to have an annual limit precludes a non-integrated HRA from having a limit[2]. Some practitioners had speculated that an individual premium reimbursement HRA that satisfies the Code Section 106(c)(2) definition that the HRA is operating as a flexible spending arrangement (FSA) could escape the annual limit provision. However, DOL Technical Release 2013-03 made it clear that these HRAs are "employer payment plans" and cannot reimburse individual insurance premiums. The regulators specify that the employer's individual premium HRA is a group health plan and, as such, cannot comply with the no annual limit provision because the cost of the individual plan purchased creates a limit on the annual amount that the HRA will reimburse and that the employer

[2] Department of Labor FAQs, January 24, 2013
[3] DOL Technical Release 2013-03, September 13, 2013
[4] CMS Insurance Standards Bulletin, August 19, 2011

payment plan cannot be integrated with any individual health insurance policy purchased with the HRA funds; thereby failing to comply with the preventive care services mandate.

Therefore, employers that provide for reimbursement of individual insurance premiums from the stand-alone HRA will not be able to continue with that plan design when the HRA renews on or after January 1, 2014.

Essential Health Benefits

Non-grandfathered, non-excepted insured individual or small employer plans purchased in the group market are required to provide a package of essential health benefits (EHBs) when those plans renew in 2014[5]. The EHB package is coverage in each of ten broad categories, such as ambulatory care, emergency services, prescription drugs, etc. This EHB package is subject to the no annual or lifetime limit provision and the cost-sharing limit on out-of-pocket (OOP) expenses.
Large employers need not provide the EHB package, but any EHB coverage cannot have an annual or lifetime limit and the EHB OOP is included in the maximum OOP cost-sharing provision explained below.

Integrated HRAs commonly are used to reimburse some of the OOP expenses incurred by the participating employee and/or family which would include coverage for EHBs covered by the medical plan the HRA is integrated with. Clearly, these integrated HRAs have a future when this provision takes effect.

Non-integrated, non-excepted HRAs are subject to this provision. Employers that offer these HRAs likely will discontinue them due to the no annual or lifetime limit provision explained above, not necessarily due to this provision.

Cost-Sharing: Out-of-Pocket Limitation

Non-grandfathered, non-excepted health plans are subject to cost-sharing limits[6] as they renew in 2014. To comply with this provision, the plan cannot cause a participant to incur out-of-pocket (OOP) expenses that exceed the maximum OOP for a high deductible health plan (HDHP) as defined in Code Section 223.

For 2014 the maximum OOP for an HDHP is $6,350 for single plan coverage and $12,700 for any coverage other than single plan (e.g., employee + spouse, family, etc.). The maximum applies to the combined OOP for deductible, co-insurance and other co-pay expenses.

Integrated HRAs commonly are used to reimburse some of the OOP expenses incurred by the participating employee and/or family under the employer's group health plan. Clearly, these integrated HRAs have a future when this provision takes effect.

[5] HHS Final Rule, February 20, 2013
[6] PHSA Section 2707(B)

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Non-integrated, non-excepted HRAs are subject to this provision. Employers that offer these HRAs likely will discontinue them due to the no annual or lifetime limit provision explained above, not necessarily due to this provision.

Cost-Sharing Limits: Deductible Maximum Limitation

Non-grandfathered, non-excepted insured individual or small employer plans purchased in the group market cannot have deductibles that exceed $2,000 for single plan or $4,000 for any coverage other than single plan (e.g., employee + child, family, etc.) when the plan renews in 2014[7]. This is a separate provision from the maximum OOP limitation, since the OOP maximum applies to deductible, co-insurance and co-pays. Large employers (those with more than 50 full time equivalent employees) are not subject to this maximum deductible cost-sharing limit

Consequently, an affected small employer plan cannot have a deductible greater than $2,000 single or $4,000 family and cannot have OOP expenses that exceed $6,350 for single coverage and $12,700 for family coverage in 2014.

Small employers that currently have deductibles greater than the maximum will need to amend those plans to have no greater than the maximum deductible when the plan renews in 2014. The regulatory guidance does not permit the employer to count HRA funding or contributions to an HSA to satisfy the out-of-pocket deductible maximum[8]. The underlying medical plan, itself, must satisfy the provision. Therefore, unless the employer amends the plan to include other out-of-pocket expenses when the deductible is decreased, it is likely that the underlying plan's premium will increase.

For example, assume a small employer currently has a health plan with a $3,000 single deductible and $6,000 family deducible after which the plan pays 100%. To renew that plan with a $2,000 single and $4,000 family deductible after which the plan pays 100% would be an increase in premium. However, the employer could include co-insurance after the deductible as a means of decreasing what the plan reimburses so that the premium increase attributable to the decrease in deductible is offset in whole or in part by the introduction of or increase in co-insurance.

Therefore, small employers that amend their plans to satisfy the deductible maximum provision are likely to include co-insurance and other copays as a way to redistribute insurance reimbursement and keep premium costs to a minimum.

The underlying health plan must comply with the maximum deductible by itself. However, an integrated HRA can be used to reimburse OOP expenses prior to the maximum deductible being satisfied as well as other OOP expenses for co-insurance or copays. Therefore, integrated HRAs in the small employer market have a future as a means of reimbursing OOP expenses incurred under the small employer's underlying health plan.

[7] PHSA Section 1302(c)(1)(A) & (B)(ii)
[8] Federal Register, February 25, 2013

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Non-integrated, non-excepted HRAs are subject to this provision. Small employers that offer these HRAs likely will discontinue them due to the no lifetime or annual limit provision explained above, not necessarily due to this provision.

Actuarial Value: The Metal Plans

The Public Health Safety Act (PHSA) provides that a non-grandfathered non-excepted health plan must measure the actuarial value of the plan (percent of the anticipated eligible expenses the plan will reimburse in a year) and communicate that value to individuals or employers that might purchase that plan as the plan renews on or after January 1, 2014[9]. The minimum actuarial value that a plan can have is 60%.

Insured individual health plans, small employer insured group health plans and health plans offered on an Exchange must satisfy one of four "metal" levels (Bronze, Silver, Gold or Platinum) for their actuarial value[10]; with Bronze being 60%, Silver 70%, Gold 80% and Platinum 90%.

In addition, the regulatory guidance allows an employer to include the newly available HRA funding it provides during a plan year when the actuarial value of the overall medical plan is calculated. Consequently, the integrated HRA could raise the actuarial value of the health plan to a higher level than what the medical plan alone would achieve[11].

Integrated HRAs commonly are used to reimburse some of the OOP expenses incurred by the participating employee and/or family under the employer's health plan. Clearly, these integrated HRAs have a future for affected small employers when this provision takes effect.

Non-integrated, non-excepted HRAs are subject to this provision. Employers that offer these HRAs likely will discontinue them due to the no lifetime or annual limit provision explained above, not necessarily due to this provision.

Patient-Centered Outcomes Research (PCOR) Fee

The PCOR fee is paid by insurers of certain insurance plans and by the plan sponsor (employer) of certain self-insured plans. The fee is payable for each covered life under the plan and for seven plan years - plan years that ended on or after October 1, 2012 through plan years ending prior to October 1, 2019 (calendar year plans pay for the 2012 plan year through the 2018 plan year)[12]. The fee is $1 per covered life per plan year for plan years ending by December 31, 2012, $2 per covered life per year for plan years ending in 2013 and $2 per covered life per year adjusted for inflation for future plan years.

Except for HRAs that are stand-alone dental or vision reimbursement HRAs, an employer's HRA is subject to this fee unless the HRA is integrated with the employer's self-insured medical plan. Therefore, most employers will be subject to paying the fee for the covered lives under the HRA.

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[9] PHSA Section 1302(d)(2)
[10] PHSA Section 1302(d)(1)
[11] IRS Notice 2012-3
[12] Federal Register, December 6, 2012

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IRS guidance allows the employer to count only the covered employees, not spouses and dependents, when calculating the covered lives under the HRA. Therefore, the fee for the HRA is really $1 per employee per year for 2012, $2 per employee per year for 2013 and $2 per employee per year adjusted for inflation in future years.

Consequently, the total fee is fairly nominal in relation to the overall administrative expenses of the HRA and is not likely to cause employers to discontinue the HRA due to this provision, alone.

Transitional Reinsurance (TR) Fee

The TR fee is paid by insurers of certain insurance plans and by the plan sponsor (employer) of certain self-insured plans. The fee is payable for each covered life under the plan for calendar years 2014, 2015 and 2016[13].

HRAs that are stand-alone dental or vision reimbursement HRAs or HRAs that are integrated with the employer's health plan are not subject to this fee. Therefore, employers that offer HRAs that are not integrated with their health plan that reimburse expenses other than dental or vision expenses are subject to paying the fee for each covered life under that HRA. However, the Health and Human Services Department issued a proposed change to this requirement to exempt retiree-only plans, including retiree-only stand-alone HRAs, from the TR fee mandate and exempt HRAs that do not use a third party administrator(TPA) from paying the TR fee for calendar years 2015 and 2016[14].

For affected non-integrated HRAs, the TR fee is about $63 per covered life for calendar year 2014, reducing to about $38 per covered life for calendar year 2015 and to about $25 per covered life for calendar year 2016.

Unlike the PCOR fee, guidance does not provide for counting only the covered employees when calculating the number of covered lives for the HRA TR fee – presumably, spouses and dependents must be included.

Consequently, the fee is more than a nominal administrative expense for the non-integrated affected HRA. Consequently, in addition to the no lifetime or annual limit provision having dramatic effect on these HRAs, the TR fee itself could be cause for affected employers to discontinue the non-integrated HRA design.

Conclusion

Health Care Reform brings with it several provisions that will affect the design and delivery of health plans in 2014 and future years. HRAs that are not integrated with the employer's group medical plan will likely be discontinued due to the impact of these provisions. However, integrated HRAs will continue to be a useful tool for employers to manage their overall health care costs.

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[13] IRS ACA Section 1341 FAQs, December 7, 2012
[14] HHS Notice of Benefit and Payment Parameters December 2, 2013

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