GBS ACA Compliance

Cash in Lieu and Opt-Out Arrangements

July 2020

Employers who offer group health insurance coverage inevitably encounter a percentage of employees who decline coverage. Some employers choose to offer these employees a form of compensating reimbursement representing the value (or a portion of the value) of the "lost" benefit. Employers of any size who offer reimbursement in the form of "opt-out" or "cash in lieu" arrangements should be aware of several ramifications of such an offering to avoid exposure to compliance penalties. Six ramifications are listed below as well as additional detail for each.

1. Opt-out payments will result in adverse tax consequences unless offered through a Cafeteria Plan.
2. Opt-out arrangements count as employee contributions in the Affordable Care Act (ACA) employer shared responsibility (ESR) affordability calculation -- unless it meets specific "eligible opt-out arrangement" requirements.
3. Opt-out arrangement may violate the Medicare Secondary Payer and similar TRICARE Secondary Payor rules unless properly structured.
4. Opt-out arrangements should not be based on participant health status factors or claims, as this would likely violate HIPAA nondiscrimination and/or Privacy rules.
5. Opt-out payments should be included as "wages" for purposes of overtime payments under the Federal Labor Standards Act (FLSA).
6. Opt-out arrangements should not be provided to purchase an individual policy, but recent changes and expansions to HRA rules like the QSEHRA, ICHRA and the EBHRA create exceptions.

1. Opt-out Arrangements, Taxability and Cafeteria Plans

Background: Cafeteria Plan rules are found in Internal Revenue Code §125 and are sometimes referred to simply as "125 Plans". Written cafeteria plans allow employees to purchase benefits offered by/through the employer with earned income that is not taxed. By definition, a cafeteria plan is a CHOICE between optional nontaxable benefits and taxable compensation.

For Example: An employee may have the choice between participating in the employer's group health plan (the nontaxable benefit) or not participating in the employer's group health plan (taxable compensation). If an employee elects to participate in the employer's group health plan, part of his/her normally taxed income would go toward monthly premiums without being taxed. If an employee does not participate, the employee's income is not reduced to pay the premiums but is instead, taxed like regular income.

Details: Opt-out payments and cash in lieu arrangements should be run through a 125 Plan. Employees who elect the cash in lieu of benefits are still taxed on the cash as regular compensation, even though it is run through the 125 plan. Employees who elect to enroll in the group health plan would enjoy the pre-tax benefits on the cost of the premium. The reason to run the cash out option through a 125 Plan is to benefit employees who elect to enroll in the health plan rather than take the cash option. Under the "constructive receipt" doctrine, if the cash option is not run through the 125 plan, an employee who elects to enroll in health benefits (rather than selecting the cash in lieu option) would still be taxed on the value of the cash in lieu option even though he/she did not select the cash in lieu option.

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The "constructive receipt" doctrine is an IRS tax term mandating that an individual must pay taxes on income despite the fact that it has not been physically received. An individual is considered to be in "constructive receipt" of funds he/she could have received but elected not to. In other words, individuals are treated as if they received the funds even though they did not. This means that even employees who decline the opt-out payment and elect to enroll in the group health plan could be required to include in gross taxable income the amount that they could have elected to take as a taxable opt-out payment or cash in lieu of benefits.

For example: Employer NiceCo will pay $450/month toward self-only medical coverage for each employee, and the employee must pay $60/month toward self-only coverage. This is a non-taxable benefit to employees. NiceCo also wants to allow employees who have coverage through a spouse's plan to opt out of NiceCo's coverage and instead receive an additional $50 per paycheck from the employer. The $50 opt-out amount, or cash in lieu option, would be taxable income to the employee. Additionally, NiceCo will have to pay its share of employment taxes, i.e., FICA/FUTA, on the $50 per pay check. If this option is offered inside a Cafeteria Plan, the $50.00 per month opt-out or cash in lieu amount will only be taxable to employees who elect it, and not to those who elect to have coverage under the NiceCo group health plan.

2. Opt-out Arrangements and "Affordability" under the ACA

Background: Under the ACA Employer Shared Responsibility (ESR) provision, a large employer (officially an Applicable Large Employer or ALE) may be subject to penalties under section 4980H(b) if coverage offered to a full-time employee is not affordable (or does not provide at least minimum value) and if that full-time employee qualifies for a subsidy when buying health insurance in the Marketplace/Exchange.

Coverage is deemed affordable if the employee's required contribution for the lowest-cost (single) coverage does not exceed 9.5% (indexed for inflation each year) of the employee's household income. Because household income may be difficult for an employer to assess, affordability may be determined through one of three affordability safe harbor methods:

- *the W-2 method,*
- *the Rate of Pay method or*
- *the Federal Poverty Level method.*

Details: Opt-out arrangements may make it more difficult for an ALE to meet the "affordability" test under the ACA ESR provisions. Opt-out arrangements must qualify as "eligible opt-out arrangements" or they will count as employee contributions under the ACA Affordability test. This rule is found in IRS proposed regulations issued July 8, 2016 (Internal Revenue Bulletin: 2016-30) which modifies IRS Notice 2015-87.

The rule: As of the first day of the 2017 plan year, all opt-out arrangements that do NOT qualify as "eligible opt-out arrangements" do count as employee contributions under the ACA Affordability test, even if the arrangement was adopted on or before December 16, 2015. This includes all unconditional opt-out arrangements, as well as conditional arrangements that do not meet specific criteria (listed below).

Steps to determine whether the opt-out is an "eligible opt-out arrangement":

- First, an eligible opt out arrangement must be a conditional arrangement:
  - An **"unconditional"** opt-out arrangement is one under which the employer pays an employee taxable cash if the employee declines employer group health plan coverage, and the employee does not have to provide any evidence of or attest to having other group health coverage. The employee can decline to enroll for any reason, even if the employee does not have other coverage. (There are no "conditions" attached to receiving the opt-out payment.)
  - A **"conditional"** opt out arrangement is one under which the employer pays an employee taxable cash only if the employee declines employer group health plan coverage AND satisfies some other meaningful requirement related to having health coverage - usually that the employee must provide proof of other group health coverage (e.g., provided by a spouse's employer).

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- Second, an eligible opt out arrangement must be a conditional arrangement that also meets the following criteria:
  - The employee must provide "reasonable evidence" that the employee and all members of the employee's tax family (dependents on his/her tax return) have or are expected to have Minimum Essential Coverage (MEC) for the relevant period (the plan year for which the opt-out payment is offered).
    - Reasonable evidence:
      - May be the employee's attestation.
      - Must be provided at least annually.
      - Must be provided no earlier than a reasonable period of time before coverage starts (e.g., at open enrollment), and employers may allow employees to provide it after the plan year starts.
  - The MEC cannot be coverage in the individual market, either on or off the exchange; but it can be government coverage such as Medicare Part A, most Medicaid, CHIP and most TRICARE programs.
  - The arrangement must provide that the employer cannot make opt-out payments (and the employer in fact must not) if the employer knows or has reason to know that the employee or family member does not or will not have MEC.

For example: The total cost for self-only coverage is $400 per month, of which the employer pays $310 and the employee pays $90. The employer also offers all eligible employees $75 per month if they decline coverage. If the $75 opt-out payment must be counted (because it is unconditional or is conditional but does not meet requirements to be an "eligible opt-out arrangement"), the employee cost for self-only coverage will be $165 per month ($90 +$75). In contrast, if the opt-out payment meets the criteria to be an "eligible" opt-out arrangement, it does not have to be counted, the employee cost for self-only coverage will be $90 per month, which is less than the FPL safe harbor of $96.08 per month for 2018.

Two Important Affordability Reminders

If an opt-out payment must be counted in the affordability calculations, it will be counted for ALL full-time employees, both those who enroll in the employer group health plan and those who decline coverage and receive the opt-out payment instead.

Even if an opt-out payment must be counted in the affordability calculations, no penalty applies if the employee enrolls in coverage, even if the coverage does not meet affordability. This is because employees who enroll in employer coverage are not eligible for a subsidy. The penalty only applies if the coverage is not affordable and the employee enrolls in exchange coverage and qualifies for a subsidy.

3. Opt-out Arrangements and Medicare/TRICARE rules

Background: Medicare and TRICARE are federal health care programs. Medicare is federal government health care coverage for ages 65 and older, or under age 65 and receiving Social Security Disability Insurance (SSDI) for a certain amount of time, or under 65 and with End-Stage Renal Disease (ESRD). TRICARE is the federal government health care program for uniformed services members, retirees and their families. When an individual is eligible for both a federal health care program **and** an employer group health plan, there are federal laws and rules that address, in part, which health plan pays (primary and secondary payer rules). These rules are lengthy and complex but the goal of secondary payer rules is to insure that employers do not shift the risk for health coverage to federal taxpayers. Consequently, the rules prohibit incenting eligible participants (for federal health care programs) away from the group health plan. The rules apply to all group health plans: insured and self/level funded health plans, and ERISA plans as well as to church and non-federal government plans that are exempt from ERISA.

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Medicare Secondary Payer (MSP) rules prohibit employers from offering financial incentives to Medicare-eligible employees to get them (or Medicare-eligible dependents) to enroll in Medicare and decline coverage in the employer group health plan that would be primary to Medicare.

TRICARE Secondary Payer rules are similar to MSP rules. This law prohibits employers from offering incentives to TRICARE-eligible employees to opt out or to terminate enrollment in an employer-offered Group Health Plan (GHP) that is or would be primary to TRICARE.

Details: Opt-out arrangements could be considered incentivizing employees to opt out of the group health plan and onto Medicare or TRICARE if a portion of employees are eligible for either. However, it appears employers are likely not in violation of Medicare/TRICARE secondary payor rules as long as all employees are offered the opt-out arrangement and as long as the offer is through a 125 Cafeteria Plan. This is because the Centers for Medicare & Medicaid Services (CMS) has informally said that an employer is not a violation of the MSP rules when employees who are entitled to Medicare have the same cash-out rights as employees who are not entitled to Medicare, under a bona fide cafeteria plan that meets the requirements of Code section 125. Thus, offering an opt-out payment when offered through a bona fide cafeteria plan to all employees, including those who are eligible for Medicare or TRICARE, does not appear to be a violation of these rules.

*Update Note: T*he language in the CMS enforcement manual appears to walk back these informal comments a bit, at least for employees without primary coverage other than Medicare.

4. Opt-out Arrangements and HIPAA nondiscrimination rules and privacy rules

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is an extensive federal law which addresses several issues including: health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. HIPAA's provisions affect group health plan coverage in the following ways: 1) provides certain individuals special enrollment rights in group health coverage when specific events occur (e.g. birth of a child); 2) prohibits preexisting condition exclusions per the ACA; and 3) prohibits discrimination in group health plan eligibility, benefits, and premiums based on any specific health factor. Discrimination based on a health factor includes: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability; and disability. Generally, distinctions among groups of similarly situated participants can be made as long as they are based on a bona fide employment-based classification consistent with the employer's usual business practice.

For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as distinct groups of similarly situated individuals, with different eligibility provisions, different benefit restrictions, or different costs, provided the distinction is consistent with the employer's usual business practice.

In addition, a plan generally under HIPAA may: 1) treat participants and beneficiaries as two separate groups of similarly situated individuals, and 2) distinguish between beneficiaries based on their relationship to the plan participant (such as spouse or dependent child) or based on the age or student status of dependent children. A plan cannot create or modify a classification directed at individual participants. It can also not charge individuals with histories of high claims more or incent individuals with high claims to opt out of the group plan.

Details: Opt-out arrangements could violate HIPAA nondiscrimination rules if an employer offers, to only employees with high claims risk, a choice between enrollment in the group health plan or cash in lieu. The IRS takes the position that this practice constitutes prohibited discrimination based on one or more health factors. Opt-out arrangements could also violate HIPAA privacy rules if an employer uses claims data from the group health plan to identify participants in the plan who are high claims risk individuals, and then offer those participants a choice between enrollment in its standard group health plan or cash. To avoid penalties, an employer should extend the opt-out offer to all employees who are eligible for group health plan coverage.

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5. Opt-out Arrangements and the Fair Labor and Standards Act (FLSA)

Background: The Fair Labor Standards Act (FLSA) established minimum wage, child labor and overtime laws. When non-exempt employees work more than 40 hours in a workweek, they are entitled to overtime wages.

Overtime pay is one and one-half times their regular hourly rate. For each hour a qualifying employee works over 40 hours, an employer must multiply the hourly rate by 1.5.

Details: Opt-out arrangements may need to be included in the rate of pay used to calculated overtime, according to a federal Circuit Court. In a 2016 California case, *Flores v City of San Gabriel,* the city offered a cash opt-out payment to police officers. The federal Ninth Circuit court held that taxable opt-out payments must be included in the rate of pay used to calculate overtime pay under the Fair labor Standards Act (FLSA), unless certain exemptions apply. One of those exemptions is where opt-out payments are an incidental portion of the benefits received. However, in the *Flores* case, the court said the opt-out payments were far more than incidental and held that the opt-out payments were taxable compensation "even though not directly tied to specific hours of work." Employers who pay overtime amounts under the FLSA should get advice from their legal counsel before offering taxable opt-out payments to hourly employees.

6. Opt-out Arrangements and Individual Policies

Background: In a series of IRS notices starting in 2012, the IRS confirmed and reconfirmed that an employer may not offer employees cash to reimburse the purchase of an individual market policy. The IRS explains that such an arrangement is group health coverage. This is because it is a "plan, fund, or other arrangement established or maintained for the purpose of providing medical care to employees." This applies whether the employer treats the money as pre-tax or post-tax to the employee. Specifically,

Employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate the ACA prohibition on annual dollar limits and the requirement to provide first dollar coverage of preventive services (no cost sharing) among other provisions, which can trigger penalties.

These arrangements are sometimes called employer payment plans or premium reimbursement plans. Under these options, an employer reimburses employees (or pays directly) for all or part of the premium for individual coverage. The IRS has deemed these to be a type of "group health plan" to which various ACA market reforms apply (such as the requirement to cover preventive care, and the prohibition on annual or lifetime dollar limits on essential health benefits) and consequently they cannot comply. For example, the premium reimbursement would by its nature impose an annual dollar limit and not an unlimited amount.

Details: To avoid penalties in the form of excise taxes under IRC section 4980D, an opt-out option should not be provided to enable employees to purchase individual policies or to provide premium reimbursement plans or . Employers should clearly state in all plan documents and communication materials that the opt-out payment is not made to reimburse employees for purchasing individual health insurance policies, whether on or off the exchange/marketplace.

Update: Exception to this rule for certain small employers

In December 2016, the passage of the 21st Century Cures Act allows small employers *who do not offer a group health plan to ANY of their employees* to offer a Qualified Small Employer HRA (QSEHRA). Employees can use these plans to pay for medical care expenses including premiums for individual health policies. To use the QSEHRA exception, there are specific rules that must be followed. Please see our December 2016 GBS summary entitled: *Small Employers: New Legislation Authorizes Stand-Alone HRA*

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Update: Exception to this rule for certain employers of any size

In June 2019, final regulations expanding the use of Health Reimbursement Arrangements (HRAs) were released. Effective January 1, 2020 employers of any size have two additional alternative options to provide insurance options for their employees.

- Individual Coverage Health Reimbursement Arrangement (ICHRA): An HRA with no maximum that is integrated with individual health insurance (on or off Marketplace Exchange) or Medicare. It must be offered on the same terms within (permitted) employee classes and may only be offered to employee classes who are not offered a traditional group health plan.
- Excepted Benefit Health Reimbursement Arrangement (EBHRA): An HRA funded at up to $1,800 a year that reimburses IRC 213(d) expenses like copays, deductibles, plus COBRA, dental and vision premiums, premiums for coverage consisting solely of excepted benefits and STLDI premiums. It may not reimburse premiums for individual health coverage, Medicaid or non-COBRA group coverage. An employer must offer a traditional group health plan to employees who are offered an EBHRA but enrollment is not required.

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