ERISA and IRS Compliance Related Issues for Alternative Funding Programs

We have compiled resources that have identified that Alternative Funding Programs may have potential ERISA and IRS-related compliance issues which are outlined below. This document provides neither legal nor tax advice; please consult your own experts.

Alternative Funding Programs (AFPs)

AFPs attempt to lower a self-funded group health plan's cost of providing specialty drugs by shifting the financial responsibility for specialty drugs from the plan to alternative funding sources such as independent charitable foundations set up by pharmaceutical companies. The alternative funding process is as follows:

- The plan is amended to expressly exclude some or all specialty drugs. This is necessary to ensure availability of alternative funding sources that are conditional on the recipient having no insurance coverage for the requested drug(s).
- The AFP works with participants who have been prescribed a non-covered specialty drug to identify and apply for alternative funding from independent third parties.
- If the alternative funding request is denied by the third party, the plan administrator "overrides" the exclusion and provides tax-free reimbursement to the participant. In most cases, written documentation is not provided.
- When alternative funding is successfully arranged, typically, the employer is billed by the AFP based on percentage of savings generated.

Potential Compliance Issues Under ERISA

Reimbursements for overrides are taxable if not provided a written plan as required by Code Section 105. If taxable, reimbursements should be reported on employee W-2s and all applicable income and employment taxes should be withheld and reported as required by the IRS.

If reimbursements are not made in accordance with the terms of the group health plan, ERISA prohibits using contributions from group health plan participants. If reimbursements are funded through the same claims account established by the employer to fund group health plan benefits, the Department of Labor (DOL) would likely argue that these have illegally been funded with plan assets.

Taxation of Reimbursements

Other issues may arise. Reimbursements are excludable from income to the extent they satisfy the requirements of Code Section 105, which requires a written plan. For the tax exclusion to apply, reimbursements must be provided through an accident and health plan.[1] Regulations do not define an accident and health plan as a "written plan"; however, courts have long held that no accident and health plan exists if the employee has not been formally notified that benefits and benefit entitlements are subject to the discretion of the employer.[2] To be excludable, benefits must be provided through a written plan. The regulations define a fully insured plan as a plan pursuant to which the benefits are provided pursuant to an insurance policy issued

[1] See 26 USC 105(a); see also 26 CFR 1.105-5(a).
[2] See Estate of Chism v. Commissioner, 322 F2d 956 (9th Cir, 1963); Lang v. Commissioner, 41 TC 352 (1963). See also 26 USC 3121(a)(2) and 3306(b), which exclude from the definition of wages for income tax and FUTA withholding any payments made pursuant to a "plan" or "system" of the employer. See also Section 3401(a)(20), which excludes from the definitions of wages for FICA benefits made through a self-insured medical reimbursement plan as defined in Code Section 105. As noted above, a self-insured medical reimbursement plan is a written plan maintained by the employer.

by a licensed insurance carrier and a self-insured plan is defined as a plan that is not insured pursuant to an insurance policy and is maintained pursuant to a "separate, written plan of the employer".[3] Regardless, in either case, to be excludable, benefits must be provided through a written plan.

Since AFPs carve out specialty drugs from the written plan, specialty drugs therefore are not a covered benefit. Consequently, reimbursements for overrides are not excludable from income under Code Section 105 even though specialty drugs constitute medical care. To the extent AFPs are disclosed in writing to employees, they could be considered a second self-insured health plan. However, such a plan would be subject to the same extensive regulatory, disclosure and tax regime as any other employer-sponsored health plan.

Reimbursements that are not excluded from income under Code Section 105 must be reported on the employee's W-2 and all applicable federal income and employment taxes must be withheld and properly reported.[4] Failure to do this could result in significant penalties for the employer. For example, failure to file a correct 941 could result in a penalty equal to 2% to 15% of the unpaid amounts, based on the length of delay. Failure to file a proper W-2 could result in up to a $280 penalty for the W-2 filed with the IRS and another $280 penalty with respect to the W-2 furnished to the employee.

Breach of Fiduciary Duty under ERISA

ERISA imposes on health plan fiduciaries the duty to ensure plan assets, such as participant contributions, are used only to provide benefits under the plan and to defray reasonable plan administration expenses.[5] In addition, a fiduciary is obligated to administer the plan in accordance with the plan's written terms.[6] Therefore, if a group health plan fiduciary uses participant contributions to pay for expenses not covered by the plan, the fiduciary breaches its duty under ERISA.[7]

If reimbursements are funded through the same employer-owned claims account that funds benefits under the group health plan, the DOL may take the position that the claims account constitutes plan assets. ERISA generally requires an employer to deposit participant contributions into a trust as soon as the contributions can be reasonably segregated from the employer's general assets. However, welfare plans, such as group health plans, that are funded through a Code Section 125 cafeteria plan are subject to a moratorium on the trust requirement set forth in DOL Technical Release 92-01. Compliance with Technical Release 92-01 enables employers to retain participant contributions made through the employer's cafeteria plan in the employer's general asset account provided that the employer takes steps to ensure that participant contributions retained in the employer's general asset account are used solely to provide plan benefits or to defray reasonable plan administration expenses.[8] Consequently, the argument that the claims account constitutes plan assets because it includes participant contributions remains to the extent that the participant contributions are not deposited into a trust.

If a breach occurs, the fiduciary may be liable for the "loss" caused to the plan by the breach.[9] A fiduciary may also be liable to individual participants for equitable relief; however, it is not clear what if any equitable relief would be appropriate in this particular situation.[10] ERISA also provides that the DOL can impose a civil penalty on the breaching fiduciary and any other person that knowingly participates in such a breach that is equal to 20% of the amount recovered by the DOL under a settlement agreement (generally resulting from negotiations with the DOL) or through an adverse court decision. The fiduciary in this instance would, at a minimum, be the plan administrator identified in the group health plan document or summary plan description. The employer is

[3] See 26 CFR 1.105-11(b).
[4] See also 26 USC 3121(a)(2) and 3306(b), which exclude from the definition of wages for income tax and FUTA withholding any payments made pursuant to a "plan" or "system" of the employer for the provision of medical benefits. See also Section 3401(a)(20), which excludes from the definitions of wages for FICA benefits made through a self-insured medical reimbursement plan as defined in Code Section 105.
[5] ERISA Section 404
[6] See ERISA 404.
[7] ERISA 3 (21) defines a fiduciary as any individual(s) that exercises discretion and control over the management and administration of the plan and/or exercise any discretionary control over the plan's assets.
[8] TR 92-01 states that "The Department cautions that the foregoing enforcement policy in no way relieves plan sponsors and fiduciaries of their obligation to ensure that participant contributions are applied only to the payment of benefits and reasonable administrative expenses of the plan."
[9] ERISA Section 409.
[10] ERISA Section 502(a)(3)

often identified in the plan documents as the plan administrator.

Providing Reimbursements Through the Plan

If the plan is amended to cover specialty drugs only to the extent that alternative funding has been sought and denied, two issues arise:

- Covering the drugs only in the event alternative funding requests are denied may cause the manufacturers and agencies to deny the request rendering the AFP ineffective. AFPs require that individuals seeking assistance have no insurance coverage for their specialty drugs. If the plan reimburses individuals when alternative funding is denied, the sources of alternative funding would likely consider these individuals to be insured.
- To the extent alternative funding is still available despite the plan provision, the plan's coverage may be considered by the IRS to violate Code Section 105(h) nondiscrimination rules, resulting in taxation of the reimbursements with respect to "highly compensated employees." Alternative funding is usually limited to lower income individuals. If alternative funding is procured for participants with lower income, plan benefits could be skewed toward highly compensated employees to an impermissible degree, or one which results in taxation to highly compensated employees.[11] Under Section 105, plans cannot discriminate in favor of highly compensated employees.[12] When they do, then the discriminatory benefits should be included in highly compensated employees' income and reported on W-2s.

Other Potential Issues

Other compliance issues unrelated to ERISA are inherent in AFPs and should be addressed by the plan sponsor:

- Manufacturers and agencies providing alternative funding may claim misrepresentation because alternative funding depends on recipients having no insurance. To obtain funding, representations are made that the individual has no insurance for specialty drugs. Since plans provide for reimbursement if assistance is not provided by an alternative funding source, such representations could be considered misleading or fraudulent.
- Information regarding the employees' income, financial resources and other factors used in the alternative funding application must be accurate when provided by the AFP to the manufacturers and agencies that offer alternative funding. Employees should not be encouraged to provide inaccurate information because doing so could constitute fraud.
- Stop loss insurance typically only provides protection for the employer with respect to amounts covered by the group health plan. If the reimbursements are not made according to the terms of the group health plan, it is unclear how paid claims for specialty drugs not covered by alternative funding sources could be covered by stop loss insurance. Care should be taken to ensure that no fraudulent information is given to the stop loss carrier to induce payment.

[11] Section 105 defines highly compensated employees as employees of the employer in the top 25% of compensation.
[12] 26 CFR 1.105-1(c)(3)(ii)