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BENEFITS BRIEF

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Guidance Eliminates Use of Stand-Alone HRA or Cafeteria Plan to Purchase Individual Health Policies But Provides Helpful Exemption for Employee Assistance Programs

On Friday, September 13, 2013, Treasury published Notice 2013-54 ("Notice"), which eliminates an employer's ability to use a stand-alone health reimbursement arrangement ("HRA") or other tax-favored arrangement, such as a cafeteria plan, to help employees pay for individual health insurance policies on a tax-free basis.[1] The Notice does this by pointing out that such arrangements would fail to satisfy the Affordable Care Act's ("ACA's") annual dollar limit and preventive health services "market reform" provisions. The Notice also discusses a long-standing exemption from certain group health plan requirements for health flexible spending arrangements ("health FSAs") that meet the definition of an excepted benefit, and provides a new exemption for Employee Assistance Programs ("EAPs") that do not provide significant benefits in the nature of medical care or treatment. The Notice applies for plan years beginning on or after January 1, 2014, but taxpayers may apply the guidance for prior periods. The chart below provides a summary of the types of arrangements that will and will not be legally permissible after the Notice takes effect, and the discussion that follows provides a more detailed explanation.

Type of Arrangement	Legally Permissible?
HRA used to purchase health policy in the individual market	No; violation of annual limit prohibition and preventive health services requirements under the ACA.
HRA used to purchase individual health policy through a public or private exchange	No; violation of annual limit prohibition and preventive health services requirements under the ACA.
HRA used to purchase coverage under a group health plan	Yes, if integrated
HRA used to purchase coverage under a group health plan in a private exchange	Yes, if integrated
HRA used to reimburse only dental or vision expenses (with no requirement that participant enroll in group health plan)	No; although Notice does not address, an HRA that reimburses dental/vision expenses would generally not satisfy the definition of a HIPAA excepted benefit.
Stand-alone retiree-only HRA	Yes; not subject to ACA's insurance market reform rules, including annual limit prohibition and preventive health services requirements.

[1] The Department of Labor ("DOL") issued substantially identical guidance on the same date (Technical Release 2013-03), and the Department of Health and Human Services issued a memorandum concurring with the IRS and DOL guidance as applied to the laws in its jurisdiction on September 16, 2013. See http://www.cms.gov/cciio/resources/regulations-and-Guidance/downloads/cms-hra-notice-9-16-2013.pdf.

Type of Arrangement	Legally Permissible?
Premium-only plans for individual coverage (employees pay a portion of premiums pre-tax through a cafeteria plan)	No; violation of annual limit prohibition and preventive health services requirements under the ACA.
After-tax premium reimbursement arrangement	Yes
Premium-only plans for group health plan coverage (employees pay a portion of premiums pre-tax through a cafeteria plan)	Yes
Payroll practice of forwarding post-tax wages to a health insurer for an individual health policy	Yes, if DOL voluntary benefit safe harbor is met
Excepted benefit health FSA	Yes
Non-excepted benefit health FSA offered through a cafeteria plan	No; violation of preventive health services requirements under the ACA (annual limit prohibition does not apply to health FSAs offered through cafeteria plans). Note that if enrollment in a group health plan is required in order to participate in the health FSA, it may be possible to argue that an FSA is an "integrated" arrangement for purposes of satisfying the preventive health services requirements.
Non-excepted benefit health FSA offered outside a cafeteria plan	No; violation of annual limit prohibition and preventive health services requirements under the ACA. Note that if enrollment in a group health plan is required in order to participate in the health FSA, it may be possible to argue that an FSA is an "integrated" arrangement for purposes of satisfying the annual limit prohibition and preventive health services requirements.
Excepted Benefit EAP (i.e., an EAP that does not provide significant benefits in the nature of medical care or treatment)	Yes
Non-Excepted Benefit EAP (i.e., an EAP that provides significant benefits in the nature of medical care or treatment)	No; violation of annual limit prohibition and preventive health services requirements under the ACA. Note that if enrollment in a group health plan is required in order to participate in the EAP, it may be possible to argue that an EAP is an "integrated" arrangement for purposes of satisfying the annual limit prohibition and preventive health services requirements.

Background

Recently, some employers have begun to explore the possibility of providing certain employee groups with contributions toward the purchase of health coverage in the individual market (e.g., on a tax-free basis through an HRA or cafeteria plan) in lieu of a traditional, employer-sponsored group health plan. The Notice is designed to discourage employers from following this approach by requiring that a participant in an HRA or other employer-sponsored arrangement that is designed to pay for health coverage on a tax-free basis also be enrolled in a group health plan. Absent group health plan enrollment and satisfaction of certain other requirements, the Notice takes the position that such arrangement would fail to satisfy two of the market reform provisions under the ACA—the

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prohibition against annual dollar limits on essential health benefits ("EHBs") and the requirement to provide certain preventive health services without cost-share.

Significantly, the Notice's application is not limited to HRAs. It creates a new term - an "employer payment plan" – that will also not comply with the annual limit and preventive health services requirements unless it meets the rules in the Notice pertaining to participation in a group health plan. An employer payment plan appears to include any tax-advantaged arrangement to pay premiums.[2] Thus, a "premium only plan," under which employees pay for a portion of health insurance premiums through a cafeteria plan on a pre-tax basis, would generally not be permitted to the extent employees are paying for individual health insurance premiums. Conversely, an "employer payment plan" does not include an employer-sponsored arrangement under which an employee may choose either cash or an after-tax amount to be applied toward health coverage. Thus, premium reimbursement arrangements made on an after-tax basis are still permitted.

With respect to health FSAs, the Notice restates rules that must be satisfied in order for a health FSA to be considered an "excepted benefit" that is exempt from the requirements that generally apply to group health plans under HIPAA, including the market reform requirements under the ACA.

With respect to EAPs, the Notice indicates that an EAP will be considered an excepted benefit as long as it does not provide significant benefits in the nature of medical care or treatment.

Below is a summary of key takeaways from the new guidance.

HRAs and Other Employer Payment Plans

Prior to the Notice, the only formal guidance on the application of the annual dollar limit prohibition to HRAs was in the preamble to the annual and lifetime limits interim final regulations, which stated that an "integrated" HRA does not violate the prohibition against annual limits on essential health benefits, as long as the other coverage offered with the integrated HRA complies with the prohibition. 75 Fed. Reg. 37188 (June 28, 2010). The interim final rule also clarified that "retiree-only" HRAs are exempt from the insurance market reforms. However, in FAQs issued on January 24, 2013 (" (HRA FAQs"), Treasury, DOL and HHS indicated that in no circumstances will an HRA be considered to be integrated with an individual policy. FAQs About Affordable Care Act Implementation, Part XI, FAQ-2. Further, the HRA FAQs indicated that if an HRA participant is not also enrolled in the employer's major medical group health plan, such participant will not be considered to be enrolled in an "integrated" HRA. FAQs About Affordable Care Act Implementation, Part XI, FAQ- 3. Neither the preamble nor the HRA FAQs defined the requirements necessary for an HRA to be considered "integrated." In addition, no prior guidance addressed the application of the preventive health services requirements to HRAs. The Notice provides as follows:

- *Individual Market Coverage* – An HRA or other employer payment plan used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the annual dollar limit prohibition or the preventive health services requirements. In an example in the Notice, a group health plan that reimburses employees for an employee's substantiated individual insurance policy premiums would not comply with the annual dollar prohibition.

[2] Some have argued that it should be possible to interpret the term "employer payment plan" more narrowly to exclude employee pre-tax salary reduction contributions paid through a cafeteria plan. However, because employee pre-tax salary reduction contributions are treated as employer contributions under the Internal Revenue Code, and because it appears that Treasury is generally trying to eliminate tax incentives for the purchase of individual health insurance policies by employees, it does not seem likely that the IRS intended this interpretation.

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- *Retiree-Only HRAs* – The market reform provisions generally do not apply to standalone (non-integrated) retiree-only HRAs. An HRA should be considered a retiree-only arrangement as long as no participant is able to receive reimbursements from the account while an active employee. It is fairly common for employers to "credit" amounts to an HRA during a participant's years of active service but not allow reimbursements until after retirement. These arrangements should be considered retiree-only HRAs. The Notice clarifies that standalone retiree-only HRAs that reimburse medical expenses, including premiums for individual health insurance policies, are minimum essential coverage under an eligible employer sponsored plan for a month that funds are retained in the HRA (even after the employer has stopped making contributions). Thus, a retiree covered by a standalone HRA will not be eligible for a Code section 36B premium tax credit for any month covered by the HRA.

- *Integration* – An HRA that is "integrated" with a group health plan (including a group health plan provided by another employer) complies with the annual dollar limit prohibition and the preventive health services requirements if the group health plan complies with the annual dollar limit prohibition and the preventive services requirements. An HRA will be "integrated" with a group health plan if it meets the requirements of either of two integration methods described in the Notice. The first method applies if the group health plan accompanying the HRA does not provide "minimum value" as defined under the ACA. The second method applies if the group health plan accompanying the HRA does provide "minimum value" as defined under the ACA. These methods are summarized in the chart below.

Method	Group Health Plan	Group Health Plan Enrollment	Group Health Plan Sponsor	HRA Participants	HRA Reimbursements	Opt Out and Termination
Group Health Plan Does Not Provide Minimum Value	Cannot consist solely of excepted benefits	Employee must actually be enrolled	Not limited to the employer • Example – can be sponsored by the spouse's employer	Only employees enrolled in traditional group major medical coverage	Limited to: • copays, • coinsurance, • deductibles, • premiums for non-HRA GHP, • non-essential health benefits (EHB) medical care HRA cannot cover a category of EHB not covered by the traditional major medical group coverage	• Must allow permanent opt out and waiver of future reimbursements at least annually • Upon termination of employment, must require remaining amounts to be forfeited or permanently opt out of and waiver of future reimbursements
Group Health Plan Does Provide Minimum Value	Must provide minimum value	Same	Same	Same	No restrictions	Same

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- *Affordability and Minimum Value* – If an employer offers an employee a group health plan and an HRA that would be integrated with the group health plan if the employee enrolled in the group health plan, amounts newly made available for the current plan year under the HRA may be considered in determining whether the arrangement satisfies Code section 36B affordability or minimum value, but not both. However, an HRA that is integrated with a group health plan offered by another employer does not count toward the affordability or minimum value requirement of the plan offered by the other employer. Also, if an employer offers an HRA on the condition that the employee enroll in group health plan coverage from another source instead of group health plan coverage offered by the employer, the HRA does not count in determining whether the employer's group health plan coverage satisfies the affordability or minimum value requirement.

- *Loss of Integrated Group Health Plan Coverage* – Unused amounts that were credited to an HRA while the HRA was integrated with other group health plan coverage may be used to reimburse medical expenses in accordance with the terms of the HRA even after the employee ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms. However, the HRA coverage will be considered minimum essential coverage, which will prevent an employee from obtaining a premium assistance tax credit for coverage purchased through the Exchange.

- *HRAs That Provide Only Dental or Vision Benefits* – Under the current regulatory structure, limited-scope dental or vision benefits will be excepted from the ACA's market reform provisions "if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan..." Treas. Reg. § 54.9831-1(c)(3). The regulation further provides that benefits are not an integral part of a group health plan unless (i) participants have the right to elect not to receive coverage for the benefits and (ii) if a participant elects to receive coverage for the benefit, the participant must pay an additional premium or contribution for that coverage. Treas. Reg. § 54.9831-1(c)(3)(ii). Consequently, because an HRA is not an insured arrangement, in order for dental or vision benefits provided through an HRA to be excepted from the ACA, employees that elect to have dental or vision coverage provided by the HRA must be charged a premium or contribution. This is problematic since an HRA must be "paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a [Code section] 125 cafeteria plan." IRS Notice 2002-45. Notice 2013-54 did not address this issue at all, but this seems like an area in which Treasury could provide relief by issuing guidance that an employee's payment of a premium for dental or vision benefits on an after-tax basis under a stand-alone HRA would not result in the plan losing its status as an HRA.

Health FSAs

The Notice makes clear that the ACA's market reform requirements do not apply to health FSAs that meet the "excepted benefit" definition. A health FSA is defined in Code section 106(c)(2) as a benefit program which provides employees with coverage under which — (A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and (B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage. Generally, this means that, as long as the maximum amount that a participant could be reimbursed from a health FSA is less than 5 x the amount that the participant could contribute to the health FSA via salary reduction, the arrangement is a health FSA. The HIPAA Portability regulations, which are quoted in the Notice, contain specific requirements that must be satisfied in order for a health FSA to be considered an excepted benefit. Under these regulations, a health FSA is an excepted benefit for a "class of participants" if it meets the definition under Code section 106(c)(2) and satisfies the following "availability" and "maximum benefit" requirements:

- *Availability:* Under the availability requirement, other group health plan coverage, not limited to excepted benefits, must be made available for the year to the class of participants by reason of their employment. Although the class of participants must be eligible for other group health plan coverage, such participants need

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not actually elect such coverage. Therefore, as long as the employer offers other major medical coverage in addition to the health FSA to all members of the class of participants, it satisfies this condition.

- *Maximum Benefit:* Under the maximum benefit requirement, the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). The "salary reduction election" is the maximum amount that the employee can apply towards his or her FSA that would have been taxable income but for the employee's election. The "maximum benefit" is the entire FSA benefit amount, which includes the sum of the employee's salary reduction and any employer contributions.

Treas. Reg. § 54.9831-1(c)(3)(v); DOL Reg. 2590.732(c)(3)(v); HHS Reg. § 146.145(c)(3)(v).

The Notice appears to assume that a non-excepted benefit health FSA will not be integrated with a group health plan, but there is still an open question regarding whether a health FSA that is not an excepted benefit (*e.g.*, because it exceeds the maximum benefit requirement) could satisfy the insurance market reforms if it is integrated with other group health plan coverage. With respect to the annual dollar limit prohibition, the Notice provides:

- *Annual Dollar Limit Prohibition* – The annual limit regulations contained an exception for health FSAs defined in Code section 106(c)(2). The Notice states that this exception was meant to be limited to only health FSAs offered through cafeteria plans because they are subject to a separate $2,500 limit on salary reduction contributions. Thus, only health FSAs offered through cafeteria plans are exempt from the annual dollar limit prohibition. The Departments are considering whether an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition.

Employee Assistance Plans ("EAPs")

EAP coverage is often provided by employers on an automatic basis to all employees without cost, whether or not the employees are enrolled in the group health plan. Absent relief, this coverage would constitute minimum essential coverage for purposes of the ACA, precluding an employee from receiving a Code section 36B tax credit, even if the employee did not have any other medical coverage. In addition, such EAP would presumably have to comply with all of the ACA's market reform requirements, including the prohibition against annual limits and the preventive health services coverage requirements. Fortunately, the Notice provides that benefits under an EAP will be considered excepted benefits as long as such benefits do not provide significant benefits in the nature of medical care or treatment. Such EAPs are not minimum essential coverage and will not prevent an employee from receiving a Code section 36B tax credit for coverage purchased through an Exchange.

Unfortunately, the Notice does not discuss wellness programs, disease management programs, or onsite clinics. Guidance is needed to address whether those programs could also be considered excepted benefits if they do not provide significant benefits in the nature of medical care or treatment.

Transition Relief

- *Cafeteria Plans*: Code section 125(f)(3), effective for taxable years beginning in 2014, prohibits employees from purchasing coverage through a public Exchange on a pre-tax basis using the employer's cafeteria plan (but, employees may still purchase coverage on a SHOP Exchange on a pre-tax basis using the employer's cafeteria plan if the employer offers SHOP coverage to its employees). However, some employers in states that have already established Exchanges have cafeteria plan provisions that allow employees to use pre-tax cafeteria plan dollars to purchase individual Exchange coverage. The Notice provides that for plans that as of September 13, 2013 operate on a non-calendar year plan year, the Code section 125(f)(3) restriction will not apply until the first

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cafeteria plan year that begins in 2014. Individuals covered under these cafeteria plans may not claim a Code section 36B premium tax credit for any month they were covered through the Exchange.

- *Amounts Credited or Made Available Before 1/1/14*: The HRA FAQs stated that the Departments anticipated that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before 1/1/14 may be used after 12/31/13 to reimburse medical expenses in accordance with the HRA terms in effect on 1/1/13 without causing the HRA to fail to comply with the annual dollar limit prohibition. The Notice, however, does not address this transition relief, and thus it is unclear whether employers can rely on the relief provided in the FAQ. Guidance is needed to address this issue.

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