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HCR Update
Health Care Reform

News on Regulations & UBA Resources
A Communication for UBA Members

IRS and DOL Issue Guidance on HRAs and Employer Payment Plans

The Department of Labor (DOL) and the Internal Revenue Service (IRS) jointly issued guidance on Sept. 13, 2013, that addresses health reimbursement arrangements (HRAs) and premium reimbursement arrangements. These releases are extremely technical, cover a range of issues, and make some significant changes in what is allowed. They are intended to prohibit payment of premiums for *individual* medical policies covering active employees and dependents on any type of a tax-favored basis. Payment of premiums for *group* medical coverage on a tax-favored basis will still be allowed. After the 2013 plan year ends, it appears that it will still be possible to:

- Provide medical, dental, vision, etc. coverage on a pre-tax basis through a group policy model (this would include exchanges like the Aon or Hanna exchanges; it also includes the SHOP marketplace and traditional group coverage provided through a Section 125 plan)
- Reimburse group medical premiums, deductibles, coinsurance, and copays through an HRA as long as the HRA is integrated with a group medical plan that meets the PPACA requirements
- Provide pre-tax coverage for "excepted benefits" like stand-alone dental, stand-alone vision, specified disease, disability, and accident coverage through either a group or an individual policy model
- Provide after-tax coverage for medical benefits through either a group or an individual policy model
- Provide voluntary (100 percent employee-paid) coverage for health benefits through either a group or an individual policy model

The agencies have long considered HRAs to be group health plans. Health flexible spending arrangements (FSAs) are considered to be group health plans for many, but not all, purposes. The Notice states that employer payment plans (discussed below) also are group health plans. Under PPACA, beginning in 2014 a group health plan cannot have dollar limits on essential health benefits; a non-grandfathered plan also must provide first dollar coverage of preventive services. These account-based plans typically have limits and/or do not provide first dollar coverage for preventive care, and therefore they generally will not be allowed after 2014. A plan that would otherwise fail may be integrated with another *group* plan so that if either of the plans meets the PPACA requirements that will be sufficient for both plans, but group and individual plans cannot be integrated with each other. An attempt to explain the IRS' reasoning is in the addendum to this update.

Permitted HRAs

As expected, the Notice effectively prohibits stand-alone HRAs unless they are limited to retirees or to reimbursement of “excepted benefits” such as stand-alone dental or vision, accident only, or specified disease coverage.

An HRA that reimburses medical expenses or premiums will be allowed if it is integrated with either the employer’s own PPACA-compliant group health plan or the group health plan of another employer (e.g., an employer can set up an HRA for employees who opt out of its plan because they have coverage through their spouse’s plan).

Integration operates a little differently depending on whether the integrated coverage provides minimum value. In all situations:

- The HRA must only be available to employees who are actually enrolled in group medical coverage (either through the employee’s or a family member’s employer), and
- The employee receiving the HRA must actually be enrolled in a group medical plan (either through the employee’s or a family member’s employer), and
- The employee must be given the opportunity at least annually to permanently decline participation in the HRA and at termination of employment either the balance must be forfeited or the employee must be allowed to permanently decline participation in the HRA

If the other plan does not provide minimum value, the HRA must be limited to reimbursing cost sharing (deductible, coinsurance, copays) and the other plan’s premiums.

If the other plan provides minimum value, the HRA may reimburse essential health benefits, in addition to cost-sharing (deductible, coinsurance, copays) and the other plan’s premiums.

The Notice is clear that the other plan does not need to have the same plan sponsor, a common plan document, or a shared Form 5500 to be considered integrated.

An integrated HRA may reimburse a former employee (including a retiree) with unused HRA dollars even after the employee’s group medical coverage ends. The Notice says that an HRA is considered to be minimum essential coverage while it has balance. Although this is often overlooked, actually being covered by an employer-sponsored plan, even if it does not provide affordable, minimum value coverage, also makes a person ineligible for a premium subsidy. Therefore, an employee must be given the opportunity to decline the HRA so that he can apply for a premium subsidy if he prefers. This means that most HRA plan documents will need to be amended to provide the opportunity to decline coverage.

If an employer chooses to make HRA contributions to employees covered under a group health plan provided by another entity, it may simply get a certification of other coverage from the employee that the employee has other group medical coverage.

Standalone retiree-only HRAs will still be allowed, and may reimburse individual premiums (such as for a Medicare supplement policy) but they will be considered minimum essential coverage for as long as there is a balance. Retirees therefore will need to decide – and be allowed to decide – if they wish to forfeit

further HRA reimbursements so that they will be eligible to receive a premium subsidy. (As a practical matter this issue will primarily affect pre-Medicare retirees.)

Standalone HRAs that are limited to excepted benefits, such as dental, vision, accident, and specified disease benefits, will still be permitted. Excepted benefit coverage is not considered minimum essential coverage, so access to this type of an HRA will not disqualify a person from receiving a premium subsidy.

Standalone HRAs will be allowed to make reimbursements even after 2013 of unused amounts contributed before 2013 and of amounts contributed during 2013 based on the terms of the plan in effect on Jan. 1, 2013. If the plan did not have a stated maximum contribution for 2013, the maximum reimbursable amount for 2013 is the maximum amount reimbursed during 2012.

Health FSAs

A health FSA that qualifies as an excepted benefit will be able to operate as it has previously. To be an excepted benefit:

- The employer must offer a group medical plan in addition to the health FSA,
- The health FSA must be provided through a Section 125 plan, and
- The employer's contribution cannot be more than the amount of any employer match (or more than $500 over the employee's contribution, if greater).

A health FSA that is not an excepted benefit will be considered a group health plan, and likely will fail to meet the PPACA dollar limit and/or preventive care requirements.

As a reminder, premiums cannot be paid out of a health FSA.

Employer Payment Plans

Premium reimbursement arrangements are now called “employer payment plans.” An employer payment plan is any arrangement under which an employer reimburses an employee for all or part of the premium for an individual health policy. Employer payment plans include direct employer payment to the insurance carrier and reimbursement of substantiated employee premium payments. According to the Notice, an employer payment plan does not include “an employer-sponsored arrangement under which an employee may choose either cash or an *after-tax* amount [emphasis added] to be applied toward health coverage.” This would seem to mean that paying pre-tax premiums through a Section 125 plan for individual coverage would be considered an employer payment plan, and will not be allowed after 2013.

Like stand-alone HRAs, employer payment plans will not meet the PPACA requirements of no dollar limits or coverage of preventive care. This means that these arrangements – that were previously allowed under IRS Revenue Ruling 61-146 – will not be allowed after this year.

After-Tax Contributions

An employer may make after tax-contributions toward the purchase of individual coverage. An employer also may facilitate an employee's purchase of individual coverage with after-tax dollars without creating ERISA obligations if:

- No contributions are made by the employer;
- Participation in the program is completely voluntary for employees or members;
- The sole functions of the employer with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions, and to remit them to the insurer; and
- The employer receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions.

Marketplace Premiums

PPACA states that premiums for individual coverage through a government marketplace cannot be paid through a Section 125 plan. A few states have exchanges that pre-date PPACA, and employers in those states may have Section 125 plans in place that allow exchange premiums to be paid with pre-tax dollars. Non-calendar year plans in those states (Massachusetts and Utah, for example) may continue on this basis until their 2014 renewal, but an employee who has a premium pre-taxed is not eligible for a premium subsidy during that time. (Coverage through a SHOP marketplace is considered group health coverage, so employees enrolled in a SHOP plan will be able to pay their premiums on a pre-tax basis.)

Private Exchanges

In addition to the tax issue, employers that wish to use a private exchange that offers individual policies need to be aware that:

- Some states consider this prohibited list billing.
- Imposing a smoker differential likely violates the HIPAA nondiscrimination requirement.

Private exchanges that use group policies do not appear to be affected by these notices. Employers considering use of a group-based private exchange need to determine whether they will use a Section 125 plan or an HRA as the funding vehicle. There has not been a definitive statement from the IRS as to how a defined employer contribution will be treated for purposes of affordability – presumably the employee's cost after the defined contribution will be measured against the cost for single coverage of the least expensive minimum value option available to determine if the employee's cost exceeds 9.5 percent of safe harbor income, but that is not yet certain.

EAPs

Employee assistance plans (EAPs) are sometimes considered group health plans. The broad definition of minimum essential coverage generated questions about whether an EAP will be considered minimum essential coverage (which would therefore disqualify the employee from receiving a premium subsidy). The new Notice states that an EAP will not be considered minimum essential coverage unless it provides

significant medical care. Unfortunately, “significant medical care” is not defined – until a definition is provided, and at least for all of 2014, employers may use any reasonable definition they wish.

IRS Notice 2013-54

DOL Technical Release 2013-03

10/8/213

Addendum

This is basically the IRS reasoning on why standalone HRA and employer payment plans will not satisfy PPACA.

All compensation and benefits provided to an employee are taxable income unless a specific provision of the tax code says the item isn't taxable income.

Internal Revenue Code Section 106 says that an employee's income does not include employer-provided coverage under an accident and health plan. This generally means that group health benefits (and premiums) aren't taxable.

To help small employers, the IRS said it would also recognize individual policies as employer-provided if certain conditions were met. This is the genesis of premium reimbursement arrangements under IRS Revenue Ruling 61-146.

Section 125 lets employee contributions to accident and health plans under Code Section 106 be made on a pretax basis. This is done by treating the employee contribution, which is made by reducing salary, as an employer contribution.

Section 125 is the only way an employee can pay premiums pre-tax. Only allowed premiums, like accident and health under Section 106, group term life and disability, can be pre-taxed.

PPACA requires accident and health (Section 106) plans to meet certain requirements, such as covering preventive care and having no dollar limits on essential health benefits (EHBs). Health reimbursement arrangements (HRAs) and premium reimbursement arrangements (PRAs) by definition have caps (the employer contribution amount or premium) and don't generally cover preventive care. Therefore these will fail as Section 106 plans in 2014, and therefore they may not be paid with pre-tax dollars since only premiums for allowed benefits can be paid through a Section 125 plan.

In contrast, most group health plans will still satisfy Code Section 106, so pre-taxing will still be allowed for those premiums.

Be aware that the complexity of this guidance has created uncertainty among some readers. However, at a recent American Bar Association conference, an IRS representative stated that the IRS believed that the Notice effectively foreclosed any direct or indirect employer payment of individual premiums after 2014, but it would issue further clarification if needed to clarify that employer payments toward individual coverage, whether the coverage is through the public marketplace, private exchange, or off-marketplace, will not be allowed going forward. (Under Section 125, employee pre-tax contributions are considered employer payments.)

10/8/2013

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