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IRS AND DOL RELEASE GUIDANCE ON HRAS AND OTHER ARRANGEMENTS THAT REIMBURSE PREMIUMS

On September 13, 2013, the Internal Revenue Service (IRS) (Notice 2013-54) and the U.S. Department of Labor (DOL) (Technical Release 2013-03) released substantially identical guidance addressing the application of annual limits and preventive care[1] to health reimbursement arrangements (HRAs); health flexible spending arrangements (health FSAs); arrangements that reimburse employees for premiums for individual health insurance coverage, referred to as "employer payment plans" (EPPs); and employee assistance programs (EAPs) under the Affordable Care Act (ACA). This guidance is generally effective for plan years beginning in 2014.

Guidance on HRAs and Employer Payment Plans

The combined guidance significantly impacts employers offering HRAs to active employees that are not integrated with group health plans, as well as employers that were contemplating using a so-called "defined contribution" approach to health insurance, once insurance products on the Marketplaces (aka "Exchanges") become available in 2014.

Employers considering a "defined contribution" approach contemplated providing their employees a tax-free pool of funds to use for the purchase of individual health insurance policies in the Marketplace or directly from a carrier. This strategy, however, is essentially prohibited by this latest guidance.

Specifically, the guidance indicates that unless an HRA qualifies as an "excepted benefit[2]," the federal agencies will consider it to violate the ACA's annual limit and preventive care rules, if it is not integrated with a group health plan. Likewise, an arrangement that reimburses employees' premiums for individual health insurance on a nontaxable basis (an EPP) will violate these rules unless it is designed as a payroll practice that complies with the DOL's rules for "voluntary" plans (i.e., it reimburses employees' premiums for individual health insurance on a *taxable basis*).[3]

In other words, it appears that employers will be prohibited from reimbursing employees for the cost of their individual health insurance policies on a nontaxable basis, regardless of whether the coverage is purchased through a Marketplace or directly from a carrier. Even if the HRA does not reimburse individual insurance premiums, it must be integrated with a group health plan, as stand-alone HRAs will violate the ACA's preventive care rules. The agencies intend to issue transition relief with respect to amounts credited to stand-alone HRAs before December 31, 2013. The agencies note

[1] The ACA generally prohibits group health plans from establishing annual dollar limits on "essential health benefits," and requires non-grandfathered group health plans to provide certain preventive services without imposing any cost-sharing requirements.

[2] An HRA is not an excepted benefit if it is designed to have an annual value that exceeds $500.

[3] A voluntary plan is one that is offered by an insurer to employees where no contributions are made by an employer, participation is completely voluntary for employees, and the employer's involvement is limited to permitting the insurer to publicize the program to employees, collecting employee premiums through payroll deductions (post-tax), and remitting them to the insurer.

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that acceleration of HRA contributions will not be permitted under the transition relief.

HRAs Integrated With a Group Health Plan

Under the guidance, an HRA is "integrated" with another group health plan for purposes of the annual dollar limit prohibition and preventive services requirements if:

1. the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits[4];
2. the employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the non-HRA group coverage;
3. the HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage;
4. the HRA is limited to reimbursement of one or more of the following – co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute essential health benefits; and
5. under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of – and waive future reimbursements from – the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

NOTE: The fourth requirement does not apply if the group health plan with which the HRA is integrated satisfies the ACA's "minimum value" standard (e.g., the plan's share of the total allowed benefit costs covered by the plan is at least 60 percent of such costs).

The opt-out requirement is necessary to preserve an individual's eligibility for a premium credit, as benefits available under an HRA will constitute minimum essential coverage (unless the HRA is an excepted benefit), which will preclude the individual from obtaining a premium tax credit to purchase coverage through a Marketplace offering.

Retiree-Only HRAs

The guidance confirms that "retiree-only" HRAs continue to be excepted benefits (and therefore are exempt from the annual limit and preventive care rules). However, a retiree covered by a stand-alone HRA for any month will not be eligible for a premium tax credit to purchase subsidized coverage through a Marketplace. The guidance notes that the ACA's affordability and minimum value requirements do not permit a retiree to obtain a premium credit if the retiree chooses to enroll in any employer-sponsored minimum essential coverage, including coverage provided through an HRA, EPP or health FSA (but only if the coverage offered does not consist solely of excepted benefits).

Health FSAs

While most health FSAs that consist solely of employee contributions are excepted benefits[5] (and therefore are exempt from the annual limit and preventive care rules), a health FSA that is not

[4] Excepted benefits include, but are not limited to, certain limited-scope dental or vision benefits, coverage for on-site medical clinics, certain benefits for long-term care and certain accident benefits.

[5] FSAs are excepted benefits if: (i) the maximum benefit payable under the health FSA for a plan year does not exceed two times the employee's salary reduction election (or, if greater, the amount of the employee's salary reduction election, plus $500); (ii) the employee has other coverage available under a group health plan of the employer for the year; and (iii) the other coverage is not limited to benefits that are excepted benefits.

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an excepted benefit must be integrated with a group health plan starting in 2014. If an employer provides a health FSA that is not an excepted benefit, the health FSA will fail to comply with the ACA's preventive care rules, because it is not integrated with a group health plan.

The agencies clarified that, although certain health FSAs that are not excepted benefits are exempt from the annual limit rules, this exemption applies only to FSAs that are offered through a cafeteria plan (clarifying the rule that HRAs cannot qualify for this exemption). This is a limited exemption, as an FSA that is not an excepted benefit will fail to comply with the preventive care rules, as noted above.

Guidance on Employee Assistance Plans

The agencies' guidance further provides that, at least through 2014, coverage under an employee assistance program (EAP) will be considered an excepted benefit (and therefore exempt from the annual limit and preventive care rules), as long as the EAP does not provide significant treatment in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment. The agencies did not offer any indication as to whether this standard may be adopted by employers struggling to develop a summary of benefits and coverage (SBCs) for their EAPs. Many employers have found it difficult to produce a meaningful SBC for an EAP benefit that rises to the level of a group health plan under DOL rules, but does not provide major medical coverage.

The agencies' guidance on HRAs and similar arrangements has widespread implications for employers and plan sponsors. Employers should carefully consider these rules as they design their employee benefits plans for 2014.

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Last updated: October 2, 2013