BREAKING NEWS

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Health Care Reform NEWS UPDATE

IRS ISSUES GUIDANCE ON THE APPLICATION OF PPACA TO HRAs, FSAs & CERTAIN OTHER EMPLOYER HEALTH CARE ARRANGEMENTS

EXECUTIVE SUMMARY

- If an employer attempts to integrate an HRA with individual coverage, the HRA may fail the requirements under PPACA's annual dollar limit prohibition and preventive services requirements, and therefore, be an invalid medical plan
- A stand-alone HRA may fail the requirements under PPACA (more guidance necessary), but an HRA that is integrated with employer-sponsored coverage, or with other coverage (e.g., spouse's plan), may be compliant with the requirements under PPACA
- Retiree-only HRAs, with less than two active employees, are still valid after January 1, 2014
- Employers may not pay for a Qualified Health Plan (QHP) in the Exchange with salary reductions under a Code § 125 plan
- Employees who enroll in an HRA, FSA, or other eligible employer-sponsored coverage, are not eligible for a premium tax credit/subsidy
- Health FSAs, as of January 1, 2014, must meet the maximum annual dollar limits requirement (speak with your Barney & Barney team to further discuss these requirements)
- EAPs may not be required to meet all of the requirements under PPACA, so long as they do not offer significant benefits in the nature of medical care or treatment

IRS ISSUES GUIDANCE ON THE APPLICATION OF PPACA TO HRAs, FSAs & CERTAIN OTHER EMPLOYER HEALTH CARE ARRANGEMENTS (CONTINUED)

On September 13, 2013, the Internal Revenue Service (IRS) issued Notice 2013-54, which explains how the Patient Protection & Affordable Care Act (PPACA) market reforms apply to certain types of group health plans, including Health Reimbursement Arrangements (HRAs), health Flexible Spending Arrangements (FSAs) and certain other employer health care arrangements. The notice also provides guidance on Employee Assistance Programs (EAPs) and the prohibition on the use of pre-tax employee contributions to cafeteria plans to purchase coverage in an Affordable Insurance Exchange (also called a Marketplace). The notice applies for plan years beginning on or after January 1, 2014, but taxpayers may apply the guidance provided in the notice for all prior periods. Highlights are covered below.

As a result of PPACA, health FSAs and HRAs have undergone slight modifications as to their guidelines, limits and treatment. New guidance and instruction has again been released in the form of Notice 2013-54 to address the application of PPACA's market reform on HRAs (stand-alone and integrated), group health plans under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy and certain health FSAs.

The market reforms specifically addressed in this notice are:

1. A group health plan (or a health insurance issuer offering group health insurance coverage) may not establish any annual limit on the dollar amount of benefits for any *individual*. This rule does not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing an annual limit on specific covered benefits that are not Essential Health Benefits (EHBs), so long as such limits are permitted under applicable law (the annual dollar limit prohibition); and
2. The requirement for non-grandfathered group health plans (or health insurance issuers offering group health insurance plans) to provide certain preventive services without imposing any cost-sharing requirements for these services (the preventive services requirements)

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

Background

- Funded solely by an employer and reimburses an employee for medical care expenses incurred by the employee, or their spouse, dependents, and any children up to age 27
- Reimbursement is excludable from the employee's income
- Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years
- HRAs generally are considered to be group health plans and are subject to the ERISA rules applicable to group health plans

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs) (CONTINUED)

Prior Guidance

- If an HRA is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual dollar limit prohibition, the combined benefit (HRA + other coverage) is in compliance with PPACA
  - An HRA is integrated with primary health coverage offered by an employer if the HRA is available only to employees who are covered by primary group health plan coverage (that meets annual dollar limit prohibition) provided by the employer
  - An employer-sponsored HRA may be treated as integrated with other coverage, only if the employee receiving the HRA is actually enrolled in the coverage
- Stand-alone HRAs, limited to retirees, that have fewer than two current employees participating in the plan, exempts the retiree-only HRA from the annual dollar limit prohibition
- Unused HRA (stand-alone or integrated with other group coverage) amounts, credited before January 1, 2014, consisting of amounts credited before January 1, 2013, and in 2013 under the terms of the HRA in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses, without causing the HRA to fail to comply with the annual dollar limit prohibition

FREQUENTLY ASKED QUESTIONS (FAQs): APPLICATION OF THE MARKET REFORM PROVISIONS TO HRAs AND CERTAIN OTHER EMPLOYER HEALTH CARE ARRANGEMENTS

Note: Only the most relevant FAQs have been included in this Breaking News piece; therefore, some FAQs may be omitted. FAQ numbering does not correspond with IRS Notice 2013-54 FAQs.

Q1: The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, because it will fail to comply with the annual dollar limit prohibition. May group health plans used to purchase coverage in the individual market be integrated with that individual market coverage for purposes of the annual dollar limit prohibition or the preventive services requirements?

A1: No. A group health plan, including an HRA, 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 services requirements.

Example:

A group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums, must satisfy the market reforms for group health plans. However, the employer payment plan will fail to comply with the annual dollar limit prohibition and preventive services requirements because:

1. An employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement; and
2. An employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement

FREQUENTLY ASKED QUESTIONS (FAQs): APPLICATION OF THE MARKET REFORM PROVISIONS TO HRAs AND CERTAIN OTHER EMPLOYER HEALTH CARE ARRANGEMENTS (CONTINUED)

Q2: How do the preventive services requirements apply to an HRA that is integrated with a group health plan?

A2: Similar to the analysis of the annual dollar limit prohibition, an HRA that is integrated with a group health plan will comply with the preventive services requirements if the group health plan with which the HRA is integrated complies with the preventive services requirements.

Q3: Under what circumstances will an HRA be integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements?

A3: An HRA will be integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if it meets the requirements under either of the integration methods described below.

Pursuant to this notice, under both methods, integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable.

Integration Method: Minimum Value Not Required

An HRA is integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements (and therefore, compliant with PPACA) if:

- The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits;
- 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 plan;
- The HRA is available only to employees who are enrolled in non-HRA group coverage, (may include a plan maintained by the employer of the employee's spouse);
- The HRA is limited to reimbursement of one or more of the following: copayments, coinsurance, deductibles, and premiums under the non-HRA group coverage, as well as medical; and
- 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. This opt-out feature is required because the benefits provided by the HRA generally will constitute Minimum Essential Coverage (MEC) under the Individual Mandate and will therefore preclude the individual from claiming a subsidy/premium tax credit in the Exchange

FREQUENTLY ASKED QUESTIONS (FAQs): APPLICATION OF THE MARKET REFORM PROVISIONS TO HRAs AND CERTAIN OTHER EMPLOYER HEALTH CARE ARRANGEMENTS
(CONTINUED)

Example (Integration Method: Minimum Value Not Required)

Facts: Employer A sponsors a group health plan and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA group coverage through a family member. Employer A's HRA is limited to reimbursement of copayments, coinsurance, deductibles, and premiums under Employer A's group health plan or other non-HRA group coverage (as applicable), as well as medical care that does not constitute EHBs. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under common ownership. Employee X attests to Employer A that he is covered by Employer B's non-HRA group coverage. When seeking reimbursement under Employer A's HRA, Employee X attests that the expense for which he seeks reimbursement is a copayment, coinsurance, deductible, or premium under Employer B's non-HRA group coverage or medical care is not an EHB.

Conclusion: Employer A's HRA is integrated with Employer B's non-HRA group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

Integration Method: Minimum Value Required

Alternatively, an HRA that is not limited with respect to reimbursements as required under the integration method expressed above is integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if:

- The employer offers a group health plan to the employee that provides Minimum Value (MV);
- The employee receiving the HRA is actually enrolled in a group health plan that provides MV, regardless of whether the employer sponsors the plan (non-HRA MV group coverage);
- The HRA is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the employer sponsors the non-HRA MV group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a plan maintained by an employer of the employee's spouse); and
- 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

Example (Integration Method: Minimum Value Required)

Facts. Employer A sponsors a group health plan that provides MV and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA MV group coverage through a family member. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA MV group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under common ownership. Employee X attests to Employer A that he is covered by Employer B's non-HRA MV group coverage and that the coverage provides MV.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA MV group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

FREQUENTLY ASKED QUESTIONS (FAQs): APPLICATION OF THE MARKET REFORM PROVISIONS TO HRAs AND CERTAIN OTHER EMPLOYER HEALTH CARE ARRANGEMENTS (CONTINUED)

Q4: May an employee who is covered by both an HRA and a group health plan with which the HRA is integrated, and who then ceases to be covered under the group health plan that is integrated with the HRA, be permitted to use the amounts remaining in the HRA?

A4: Whether or not an HRA is integrated with other 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 after an employee ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms.

Note: Coverage provided through an HRA, other than coverage consisting solely of excepted benefits, is an eligible employer-sponsored plan and, therefore, MEC under the Individual Mandate.

Q5: Does an HRA impose an annual limit in violation of the annual dollar limit prohibition if the group health plan with which an HRA is integrated does not cover a category of EHBs and the HRA is available to cover that category of EHBs (but limits the coverage to the HRA's maximum benefit)?

A5: In general, an HRA integrated with a group health plan imposes an annual limit in violation of the annual dollar limit prohibition if the group health plan with which the HRA is integrated does not cover a category of EHBs and the HRA is available to cover that category of EHBs and limits the coverage to the HRA's maximum benefit. This situation should not arise for a group health plan funded through non-grandfathered health insurance coverage in the small group market, as small group market plans must cover all categories of EHBs, with the exception of pediatric dental benefits, if pediatric dental benefits are available through a stand-alone dental plan offered.

However, under the integration method available for plans that provide MV described under Q&A 3 (above), if a group health plan provides MV for Exchange subsidy purposes, an HRA integrated with that group health plan will not be treated as imposing an annual limit in violation of the annual dollar limit prohibition, even if that group health plan does not cover a category of EHBs and the HRA is available to cover that category of EHBs and limits the coverage to the HRA's maximum benefit.

GUIDANCE UNDER THE SOLE JURISDICTION OF THE TREASURY DEPARTMENT AND THE IRS ON HRAs AND CODE § 125 PLANS

Background

- If an employer reimburses an employee's substantiated premiums for non-employer-sponsored hospital and medical insurance, the payments are excluded from the employee's gross income
  - Exclusion also applies if the employer pays the premiums directly to the insurance company
  - 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
- Individual employers may establish payroll practices of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee without establishing a group health plan, if certain standards are met

GUIDANCE UNDER THE SOLE JURISDICTION OF THE TREASURY DEPARTMENT AND THE IRS ON HRAs AND CODE § 125 PLANS (CONTINUED)

Q6: Will an HRA that has fewer than two participants who are current employees on the first day of the plan year (e.g., a retiree-only HRA) qualify as MEC for purposes of the Individual Mandate and the Exchange subsidy?

A6: Yes. The Treasury Department and the IRS understand that some employers are considering making amounts available under stand-alone retiree-only HRAs to retired employees so that the employer would be able to reimburse medical expenses, including the purchase of an individual health insurance policy. For this purpose, the stand-alone HRA would constitute an eligible employer-sponsored plan under the Individual Mandate, for a month in which funds are retained in the HRA (including amounts retained in the HRA during periods of time after the employer has ceased making contributions). As a result, a retiree covered by a stand-alone HRA for any month will not be eligible for a premium tax credit/subsidy for that month. Note that unlike other HRAs, the market reforms generally do not apply to a retiree-only HRA and therefore would not impact an employer's choice to offer a retiree-only HRA.

Q7: How are amounts newly made available under an HRA treated for purposes of the premium tax credit/subsidy?

A7: An individual is not eligible for the individual coverage, premium tax credit/subsidy if the individual is eligible for employer-sponsored coverage that is affordable (premiums for self-only coverage do not exceed 9.5 percent of household income) and provides MV (the plan's share of costs is at least 60 percent).

Amounts newly made available for the current plan year under the HRA that an employee may use only to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan count only toward the MV requirement.

Amounts newly made available for the current plan year under the HRA that an employee may use to pay premiums or to pay both premiums and cost-sharing under the primary employer-sponsored plan count only toward the affordability requirement.

Even if an HRA is integrated with a plan offered by another employer for purposes of the annual dollar limit prohibition and the preventive services requirements (see Q&A 3 of this notice), the HRA does not count toward the affordability or MV requirement of the plan offered by the other employer.

For purposes of the premium tax credit/subsidy, the requirements of affordability and MV do not apply if an employee enrolls in any employer-sponsored MEC, including coverage provided through a Code § 125 plan, an employer payment plan, a health FSA, or an HRA, but only if the coverage offered does not consist solely of excepted benefits. If an employee enrolls in any employer-sponsored MEC listed above, the employee is ineligible for a premium tax credit/subsidy.

Q8: Effective for taxable years beginning after December 31, 2013, the term qualified benefit under a Code § 125 plan does not include any QHP offered through an Exchange. This effectively prohibits an employer from providing a QHP offered through an Exchange as a benefit under the employer's Code § 125 plan.

However, if the employer's Code § 125 plan operates on a plan year other than a calendar year, may the employer continue to provide the Exchange coverage through a Code § 125 plan after December 31, 2013?

A8: For Code § 125 plans that as of September 13, 2013 operate on a plan year other than a calendar year, the restriction will only apply to plan years that begin on or after January 1, 2014. Thus, for the remainder of a plan year beginning in 2013, a QHP provided through an Exchange as a benefit under a Code § 125 plan will not result in all benefits provided under the plan being taxable.

However, individuals may not claim a premium tax credit/subsidy for any month in which the individual was covered by a QHP provided through an Exchange as a benefit under a Code § 125 plan.

HEALTH FLEXIBLE SPENDING ACCOUNTS

Background

- Designed to reimburse employees for medical care expenses incurred by the employee, or the employee's spouse, dependents, and any children up to age 27
- Contributions to a health FSA offered through a cafeteria plan are tax free to the employee
- Contributions can include employer and employee contributions
- For plan years beginning after December 31, 2012, the amount of the salary reduction is limited to $2,500 (indexed annually for plan years beginning after December 31, 2013). Additional employer contributions are not limited, so long as the FSA still qualifies as an excepted benefit
- If an FSA is determined to be an excepted benefit, PPACA market reforms generally do not apply
  - A health FSA may be considered to provide only excepted benefits if other group health plan coverage not limited to excepted benefits is made available for the year to employees by the employer and is structured as an excepted FSA

Frequently Asked Questions (FAQs): Application of the Market Reforms to Certain Health FSAs

Note: Only the most relevant FAQs have been included in this Breaking News piece; therefore, some FAQs may be omitted. FAQ numbering does not correspond with IRS Notice 2013-54 FAQs.

Q9: How do the market reforms apply to a health FSA that does not qualify as an excepted benefit?

A9: Health FSAs will be considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). Therefore, a health FSA that is considered to provide only excepted benefits is not subject to the market reforms (i.e., the annual dollar limit prohibition, and preventive services requirements).

If an employer provides a health FSA that does not qualify as an excepted benefit, the health FSA generally is subject to the market reforms, including the preventive services requirements. Because a health FSA that is not excepted benefits is not integrated with a group health plan, it will fail to meet the preventive services requirements.

The Department of the Treasury and the IRS understand that questions have arisen as to whether HRAs that are not integrated with a group health plan may be treated as a health FSA. Assuming that the maximum amount of reimbursement which is reasonably available to a participant under an HRA is not substantially in excess of the value of coverage under the HRA, an HRA is a health FSA. This statement was intended to clarify the rules limiting the payment of long-term care expenses by health FSAs.

The Department of the Treasury and the IRS are also considering whether an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition. In any event, the treatment of an HRA as a health FSA that is not excepted benefits would not exempt the HRA from compliance with the other market reforms, including the preventive services requirements, which the HRA would fail to meet because the HRA would not be integrated with a group health plan. This analysis applies even if an HRA reimburses only premiums.

Q10: The interim final regulations regarding the annual dollar limit prohibition contain an exemption for health FSAs. Does this exemption apply to a health FSA that is not offered through a Code § 125 plan?

A10: No. The Departments intended for this exemption from the annual dollar limit prohibition to apply only to a health FSA that is offered through a Code § 125 plan. There is no similar limitation on a health FSA that is not part of a Code § 125 plan, and thus no basis to imply that it is not subject to the annual dollar limit prohibition.

To clarify this issue, the Departments intend to amend the annual dollar limit prohibition regulations to conform to this Q&A 10 retroactively applicable as of September 13, 2013. As a result, a health FSA that is not offered through a Code § 125 plan is subject to the annual dollar limit prohibition and, therefore, will fail to comply with the annual dollar limit prohibition.

GUIDANCE ON EMPLOYEE ASSISTANCE PROGRAMS

Q11: Are benefits under an employee assistance program or EAP considered to be excepted benefits?

A11: The Departments intend to provide that benefits under an employee assistance program or EAP are considered to be excepted benefits, but only if the program does not provide significant benefits in the nature of medical care or treatment. Excepted benefits are not subject to the market reforms and are not MEC under the Individual Mandate. Until rulemaking is finalized, through at least 2014, the Departments will consider an EAP to constitute excepted benefits only if the EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.

Action

Employers should be aware that certain non-integrated HRAs and health FSAs may fail to meet the requirements of PPACA beginning January 1, 2014. Employers with stand-alone HRAs are encouraged to integrate their HRAs with health coverage as described above. Employers with health FSAs should speak with their Barney & Barney team to ensure that their health FSA qualifies as an excepted benefit. Employers who plan to, or have already implemented a policy to pay for Exchange coverage for employees through a Code § 125 plan should modify this policy after the end of the 2013 plan year.

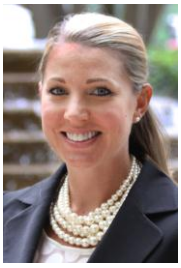
Employees should also be informed of the possibility that their employer-sponsored plan may affect their eligibility for a premium tax credit/subsidy. In addition, employees should also be informed of the impact the employer-sponsored coverage may have on the Individual Mandate and any penalties associated with it.

This notice applies for plan years beginning on and after January 1, 2014; however, taxpayers may apply the guidance provided in this notice for all prior periods. If legislative action is taken by any government entity modifying the terms of a pre-existing HRA, a health FSA that does not qualify as excepted benefits, an employer payment plan, or other similar arrangement, sponsored by a government entity, as an employer, to avoid a failure to comply with the market reforms, the applicability date of the portions of this notice under which such arrangement would otherwise fail to comply with the market reforms is extended to the later of (1) January 1, 2014, or (2) the first day of the first plan year following the first close of a regular legislative session of the applicable legislative body after September 13, 2013.

To view the complete notice, go to:

http://www.irs.gov/pub/irs-drop/n-13-54.pdf

Contact



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