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CLIENT ALERT

Will your HRA or FSA Survive the Affordable Care Act? Answering Your Questions About Technical Release 2013-03

September 27, 2013

Q&A: New Guidance on Defined Contribution Health Arrangements

The following questions and answers were originally prepared by Crowell & Moring, LLP on behalf of the American Benefits Council, to highlight some of the more significant aspects of IRS Notice 2013-54 and Department of Labor Technical Release 2013-03 (the "New Guidance") for employers and plan administrators. Our detailed analysis of the New Guidance follows below.

Q1: Can an employer sponsor a stand-alone HRA for its active employees?

A1: No. The New Guidance reiterates past guidance from the Agencies in providing that an employer cannot sponsor an HRA for its active employees, unless the HRA is "integrated" with an underlying major medical plan that does not consist solely of what are called HIPAA-excepted benefits. (HIPAA-excepted benefits are certain categories of benefits that are not subject to HIPAA's portability requirements-- for example, dental or vision benefits that are offered under a separate insurance policy or contract, or are not considered an "integral part of the plan" under law.) Thus, an HRA must be only available to employees who are enrolled in qualifying employer-sponsored major medical coverage- otherwise, it will violate PPACA's market reforms.

Q2: Can an employer sponsor a stand-alone HRA for its retirees?

A2: Yes, so long as the stand-alone HRA is offered as a retiree-only plan. Per prior Agency guidance, plans that cover only retirees are not subject to PPACA's market reforms. Thus, an employer may offer a stand-alone HRA to its retirees as part of a retiree-only plan. Employers should keep in mind that the HRA will constitute "minimum essential coverage" under PPACA. Such an arrangement will allow retirees who have not yet reached age 65 to use the coverage to satisfy the individual mandate under PPACA, but those retirees will not be eligible to receive any federal premium subsidies (and cost-sharing reductions) if they purchase individual insurance on the Exchanges.

Q3: Can an employer allow employees to pay for individual insurance purchased *from a state or federally-facilitated Exchange* on a pre-tax basis through the employer's cafeteria plan?

A3: No. PPACA, as well as the New Guidance, makes clear that an employee cannot pay for Exchange-based individual insurance through an employer's Internal Revenue Code (Code) Section 125 cafeteria plan.

Q4: Can an employer allow employees to utilize a cafeteria plan to pay on a pre-tax basis for individual insurance purchased *outside* of a state or federally-facilitated Exchange?

A4: It is not entirely clear, but we believe there may be a good argument it can. As noted above, the New Guidance makes clear that an employee cannot access an employer's cafeteria plan to pay for Exchange-based individual insurance. What is less clear

is whether an employee may be permitted to pay on a pre-tax basis through a cafeteria plan for individual insurance purchased *outside* of an Exchange. The basis for the uncertainty stems from the New Guidance which, as discussed below, precludes the use of arrangements called "employer payment plans." While we hope that the Agencies will clarify that these type of arrangements do not include cafeteria plans if used by employees to pay for individual insurance purchased outside of an Exchange, we understand the Agencies are considering this issue.

Q5: Can an employer pay on a tax-favored basis (either directly or through reimbursement) for some or all of an employee's cost of individual insurance where purchased from an Exchange? Or outside an Exchange?

A5: Based on the New Guidance, the answer appears to be "no." As noted above, the New Guidance confirms that stand-alone HRAs are not permitted. Thus, HRAs, which up until now have been a commonly-used tax-advantaged vehicle for reimbursing an employee's costs for qualified medical expenses (including medical insurance premiums) generally can no longer be used for this purpose.

Additionally, the New Guidance provides that "employer payment plans" also may not be utilized. The New Guidance defines an employer payment plan to be a group health plan under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee.

In light of the New Guidance, it appears that an employer may not pay for an employee's individual insurance on a tax-favored basis – whether through direct payment or subsidy or through reimbursing an employee for his or her incurred individual insurance premium costs.

Q6: If an employer sponsors "minimum value" health coverage for its employees, what does it need to do to ensure that its HRAs are integrated with group health coverage in order to meet the PPACA requirements?

A6: An employer can use one of two tests to determine if an HRA is properly integrated with group health coverage that provides "minimum value." The first test can *only* be used if the group health coverage provides "minimum value," and the following criteria must be satisfied:

- The employer must offer a group health plan to the employee that provides minimum value;
- The employee receiving the HRA must actually be enrolled in group health plan coverage that provides minimum value;
- The HRA must be available only to employees who are enrolled in minimum value group health plan coverage; and
- Under the terms of the HRA, the employee must be permitted, on an annual basis, to permanently opt out of and waive future reimbursements. In addition, upon termination, the employee must be permitted to permanently opt out of and waive future reimbursements, or all amounts in the HRA must be forfeited.

Alternatively, the arrangement can meet the requirements of the New Guidance if it satisfies the criteria described in the following Q&A (which can also be used for group health coverage that does *not* provide "minimum value").

Q7: If an employer sponsors major medical coverage for its employees, but it is *not* provide corresponding "minimum value" coverage, what does it need to do to ensure that its HRAs are integrated with group health coverage in order to meet the PPACA requirements?

A7: In order for the coverage that does not provide minimum value to be deemed integrated under the New Guidance, the following criteria must be satisfied:

- The employer must offer a group health plan to the employee that *cannot* consist solely of excepted benefits;
- The employee receiving the HRA must actually be enrolled in group health plan coverage that does not consist solely of excepted benefits. Note that the employee does not have to be enrolled in the employer's plan; for example, the employee could be enrolled in a group health plan maintained by the employer of the employee's spouse;
- The HRA must be available only to employees enrolled in non-HRA group coverage;
- The HRA is limited to one or more of the following categories of items for reimbursement: 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
- Under the terms of the HRA, the employee must be permitted, on an annual basis, to permanently opt out of and waive future reimbursements. In addition, upon termination, the employee must be permitted to permanently opt out of and waive future reimbursements, or all amounts in the HRA must be forfeited.

Q8: Can an employer have an HRA that is integrated with coverage consisting solely of HIPAA-excepted benefits?

A8. It is not entirely clear at this time. Under the New Guidance, an HRA generally cannot be integrated with a group health plan that provides only HIPAA-excepted benefits under the integration tests set forth above. However, some employers have considered establishing HRAs that would, by their terms, be able to only reimburse claims related to HIPAA-excepted benefits, and provide those HRAs in conjunction with a group health plan that only covers HIPAA-excepted benefits. It is not clear whether this arrangement would be considered HIPAA-excepted by the Agencies and therefore not subject to the market reforms. We expect further guidance may be forthcoming on this issue.

Q9: What happens if an employer offers a stand-alone HRA – or an HRA that is not sufficiently integrated with qualifying major medical coverage?

A9: Depending on its specific terms, the HRA would be in violation of PPACA's market reforms, including possibly the prohibitions on the use of annual and lifetime dollar limits on essential health benefits (EHBs) and the requirement to provide "first-dollar" preventive care benefits. The penalties for violating each market reform are generally $100 per day, per affected individual.

One other thing to keep in mind is that the HRA will qualify as "minimum essential coverage" for any individual who enjoys coverage under the HRA. As such, the individual will be deemed to have satisfied his individual mandate obligation under the Code by reason of the HRA coverage (at least for any month in which he has such coverage). However, the individual (including

an employee's spouse and/or dependents who indirectly enjoy coverage via the employee's HRA) will be ineligible for any federal subsidies offered through the Exchange (including premium tax credits and cost-sharing reductions). The HRA coverage may also limit an individual's ability to enroll in Exchange-based coverage more generally.

Q10: What rules apply to non-integrated HRAs with existing account balances?

A10: The Agencies had previously signaled in guidance that they would be providing special rules for HRAs with respect to account balances existing as of January 1, 2014. Unfortunately, the New Guidance does not include such rules. Moreover, such rules, if issued, would appear to only extend to amounts credited under the terms of an HRA in effect as of January 1, 2013. In the absence of special transition rules, it appears that if existing account balances in non-integrated HRAs are available to employees next year, those HRAs could be found to violate the Act's market reforms (see above), which could result in material financial penalties accruing to the employer plan sponsor. Additionally, these HRAs would seem to constitute "minimum essential coverage" for any individual covered under the HRA (including an employee's spouse and/or dependents who indirectly enjoy coverage via the employee's HRA).

We understand the Agencies are considering issuing additional guidance regarding the treatment of such existing account balances.

Q11: Can an employer continue to sponsor a stand-alone health FSA for its employees?

A11. Yes, so long as the health FSA qualifies as HIPAA-excepted. A health FSA is 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 the FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).

Q12: An employer sponsors an employee assistance program (EAP) for its employees. Can the EAP satisfy the individual mandate for those employees? Can participating in the EAP disqualify an employee from eligibility for federal premium subsidies related to the purchase of Exchange-based individual insurance?

A12: Maybe. The New Guidance provides that benefits under an EAP will be considered HIPAA-excepted benefits, and thus not minimum essential coverage and not subject to the market reforms, if the EAP does not provide significant benefits in the nature of medical care or treatment. Thus, an EAP that is deemed to not provide significant benefits in the nature of medical care or treatment will not constitute minimum essential coverage, and therefore being covered by such an EAP would not satisfy the individual mandate, nor preclude an employee from being eligible for premium subsidies on an Exchange. At least through 2014, employers may use a reasonable, good faith interpretation of whether an EAP provides "significant benefits in the nature of medical care or treatment."

Following is an article also prepared by Crowell & Moring, LLP on behalf of the American Benefits Council, that provides additional analysis regarding the New Guidance. If you have questions or would like more information, please contact the professional(s) listed at the end of the article, or your regular Crowell & Moring contact.

Agencies Issue Much-Anticipated Guidance Regarding PPACA Market Reforms and HRAs, FSAs, and EAPs

On September 13, 2013, the Internal Revenue Service (IRS) issued Notice 2013-54 and the Department of Labor (DOL) issued Technical Release 2013-03.[1] The two pieces of guidance (collectively, the "New Guidance") are substantially identical and address many previously unanswered questions regarding how market reform and other provisions of the Patient Protection and Affordable Care Act (PPACA) apply to health reimbursement arrangements (HRAs), including HRAs integrated with group health plans; health flexible spending arrangements (health FSAs); and employee assistance programs (EAPs).

In light of the New Guidance, employers should immediately review their plan offerings and benefit strategies for 2014 to ensure compliance.

Significant issues addressed in the New Guidance include the following:

- Affirmation that a *stand-alone* HRA cannot satisfy PPACA's market reform requirements, and therefore is generally not a viable option for providing employer-sponsored health coverage to active employees.

- However, an HRA that is *integrated* with a plan which meets PPACA's market reform requirements is PPACA-complaint.There are two prescriptive tests for determining whether an HRA is integrated for purposes of the New Guidance.

- Other types of tax-favored financing vehicles, such as employer payment plans under Rev. Rul. 61-146, are considered health plans and therefore cannot be PPACA-compliant on a stand-alone basis because they would violate the market reforms.

- A stand-alone retiree-only HRA will be considered an eligible employer-sponsored plan and minimum essential coverage, and, as a result, a pre-age 65 retiree covered by such an HRA will not be eligible for premium tax credits and cost-sharing reductions with respect to Exchange-based coverage. As discussed below, strategies may be available to employers to preserve HRA account balances for retirees, while ensuring a retiree's eligibility for the premium tax credits/cost-sharing reductions for a given calendar year.

- Benefits under an employee assistance program (EAP) will generally be considered HIPAA-excepted benefits and therefore not subject to PPACA's market reforms, provided that the EAP does not provide "significant benefits in the nature of medical care or treatment."

- Except for limited relief for non-calendar year plans in existence on September 13, 2013, an employee is not permitted to pay for individual Exchange-based insurance on a pre-tax basis through his or her employer's Internal Revenue Code Section 125 cafeteria plan.

- A health FSA that provides only excepted benefits is not subject to PPACA's market reforms.

Health Reimbursement Arrangements (HRAs)

An HRA is a plan funded solely by an employer that reimburses the medical expenses of an employee and certain dependents up to a maximum amount for a year, with unused amounts in the account available to reimburse medical expenses in future years. These reimbursements are generally excludable from the employee's income.

As part of PPACA's market reforms, plans and issuers are generally prohibited from imposing lifetime or annual limits on the dollar value of essential health benefits. In June 2010, the Departments of the Treasury, Labor, and Health and Human Services (collectively, the "Agencies") released interim final rules addressing the prohibition on lifetime and annual limits, and addressed HRAs in the preamble. The Agencies distinguished between HRAs that are "integrated" with other coverage as part of a group health plan and HRAs that are not integrated (also known as "stand-alone" HRAs), noting that "[w]hen HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the [annual and lifetime limit requirements], the fact that benefits under the HRA by itself are limited does not violate [those rules] because the combined benefit satisfies the requirements." However, many questions remained regarding what constitutes adequate integration for purpose of this rule.

Additionally, some employers may have been considering eliminating their employer-sponsored group health plan coverage and establishing stand-alone HRAs for their employees, with the idea being that employees could use HRA dollars to purchase individual insurance on the Exchanges. However, on January 24, 2013, the Agencies released sub-regulatory guidance in the form of a Frequently Asked Question (FAQ)[2] and confirmed that an employer-sponsored stand-alone HRA could not be integrated with individual market coverage, or with an employer plan that provides coverage through individual policies. The FAQ also confirmed that, for an HRA to be considered an integrated HRA, the employee must be enrolled in primary health plan coverage (not just offered the coverage). It therefore became clear, based on these prior issuances, that a stand-alone HRA would violate the prohibition on annual and lifetime limits pursuant to PPACA (unless offered as part of a retiree-only HRA, as discussed below).

The New Guidance provides the following additional guidance regarding HRAs:

Generally, stand-alone HRAs offered by employers to their active employees cannot be PPACA-compliant.

In addition to reaffirming the prior guidance that stand-alone HRAs cannot meet the annual and lifetime limit requirements, the New Guidance indicates that the Agencies' position is that a stand-alone HRA also cannot meet the preventive care requirements. This is because a stand-alone HRA cannot provide preventive services without cost-sharing in all instances.

Comment: Since stand-alone HRAs cannot meet the market reform requirements of PPACA, it appears that such HRAs will no longer be a viable means for employers to subsidize an employee's cost of individual insurance on a tax-free basis. However, since there is an exemption from the requirements of the Internal Revenue Code (Code) and the Employee Retirement Income Security Act of 1974 (ERISA) under PPACA for plans with fewer than two current employees, stand-alone HRAs can be offered to retirees (see below for further discussion regarding retiree-only stand-alone HRAs). In addition, as discussed below, if an employee participating in an integrated HRA loses group health coverage, the employee can still use the amounts remaining in what would then be a "stand-alone" HRA, and the HRA will still be considered PPACA-compliant employer-sponsored coverage.

The New Guidance confirms and expands upon prior guidance that HRAs may continue to be offered if integrated with a plan that meets PPACA's market reform requirements.

As discussed above, prior guidance clarified that an HRA that is integrated with an employer's major medical plan may be PPACA-compliant to the extent the related medical plan satisfies the annual and lifetime limit prohibition of PPACA without regard to the HRA. The New Guidance clarifies that an integrated HRA can also meet PPACA's preventive care requirements, if the group health plan that is integrated with the HRA independently meets those requirements. Most group health plans are required to meet the market reform obligations in order to be in compliance with PPACA, except for plans that only provide HIPAA-excepted benefits.[3]

Comment: This is welcome news for employers, as it confirms that HRAs can continue to be offered to employees, provided that such HRAs are properly integrated with other coverage. However, employers will have to review whether their integrated HRAs meet one of the tests described below, and carefully monitor that they continue to meet those tests. Otherwise, employers could be subject to material penalties for providing a health plan that is not compliant with PPACA's market reforms.

An HRA will be considered "integrated" if it meets either of two tests established by the agencies.

In order to provide additional guidance to allow employers to determine if their HRAs and group health plan arrangements are "integrated," the Agencies have established two tests as set forth in the New Guidance One test requires the employer to sponsor a group health plan that provides "minimum value" under PPACA (generally, if the plan is expected to pay at least 60 percent of the total allowed cost of benefits). The other test can be utilized by plans that do not provide "minimum value."

Comment: These tests do not appear to constitute safe harbors, such that an employer could demonstrate integration using some other means/facts. These two tests appear to be the sole means for demonstrating adequate integration.

Under the "minimum value *required*" test, the arrangement must meet each of the following arrangements:

- The employer offers a group health plan to the employee that provides minimum value;
- The employee receiving the HRA must actually be enrolled in group health plan coverage that provides minimum value;
- The HRA must be available only to employees who are enrolled in minimum value group health plan coverage; and
- Under the terms of the HRA, the employee must be permitted, on an annual basis, to elect to permanently opt out of and waive future reimbursements. In addition, upon termination, the employee must be permitted to permanently opt out of and waive future reimbursements, or all amounts in the HRA must be forfeited.

Under the "minimum value *not required*" test, the arrangement must meet each of the following requirements:

- The employer must offer a group health plan to the employee that cannot consist solely of excepted benefits;

- The employee receiving the HRA must actually be enrolled in group health plan coverage that does not consist solely of excepted benefits. Note that the employee does not have to be enrolled in the employer's plan; for example, the employee could be enrolled in a group health plan maintained by the employer of the employee's spouse;

- The HRA must be available only to employees enrolled in non-HRA group coverage;

- The HRA is limited to one or more of the following categories of items for reimbursement: 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

- Under the terms of the HRA, the employee must be permitted, on an annual basis, to elect to permanently opt out of and waive future reimbursements. In addition, upon termination, the employee must be permitted to permanently opt out of and waive future reimbursements, or all amounts in the HRA must be forfeited.

Comment: Note that under the "minimum value *required*" test, the items that can be reimbursed through the HRA are *not* limited as they are under the "minimum value *not required*" test.

As noted above, both tests provide for a mandatory permanent "opt-out" right. It appears the regulators included this requirement because the benefits provided through the HRA will generally constitute "minimum essential coverage," as discussed below. Thus, a participant with an HRA balance generally cannot qualify for premium tax credits on the Exchange (or cost-sharing reductions), even if he or she terminates employment and becomes ineligible for group health plan coverage through an employer, to the extent he or she remains eligible to reimburse medical costs (including premiums) from the HRA. The "opt-out" feature allows the former employee to forfeit the HRA balance in order to potentially become eligible for the tax subsidies on the Exchange.

One issue not addressed by the New Guidance is whether the HRA could also provide for a *temporary* "opt-out" right. Such a temporary opt-out right would allow an employee to choose whether to opt out of HRA coverage on an annual basis. The employee could not obtain reimbursements in the year that he or she opted out, but the HRA balance would not be forfeited. Under such a regime, the employee could then opt back in to the HRA in future years and obtain access to reimbursements through the HRA. Arguably, the employee could be eligible for the Exchange tax subsidies in any year during which he or she "opted out" of the HRA coverage. We note that, in the New Guidance's discussion of retiree-only HRAs, the Agencies took the position that HRA coverage would constitute "minimum essential coverage" (and therefore render the retiree ineligible for Exchange tax subsidies) for any month in which funds are *retained* in the HRA. This suggests that a temporary "opt-out" structure may not allow an employee to become eligible for the subsidies.

An important aspect of these integration tests is that *they do 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. It is very clear that an HRA can satisfy the integration tests provided that the employee is enrolled in any group health plan that meets the requirements of the test,

not necessarily one sponsored by the employer.

That allows, for example, an employee to enroll in group health plan coverage through his or her spouse and still be eligible to enroll in an integrated HRA through his or her employer. However, in order for the employer to be sure that the HRA which it sponsors continues to meet one of the integration tests and is therefore PPACA compliant, in theory it will have to monitor the other plan to make sure it satisfies the requirements of the integration test and regularly verify whether its employee continues to actually be enrolled in the other employer's plan. Tracking to confirm these requirements are met would likely be an administratively complex challenge for employers.

Alternatively, an employer might be able to amend the provisions of its HRA to include terms that would prevent reimbursement of any employee's claim if the employee is not actually enrolled in group health coverage that satisfies the integration test. Under this approach, if the employee then loses coverage, the plan sponsor could then argue that any reimbursement made by the HRA should simply be treated as taxable income to the employee and not result in the HRA failing to meet the PPACA market reform requirements. Another strategy would be for the employer to require its employees to participate in its own group health plan in order to participate in the integrated HRA, and not offer HRA coverage to employees that enroll in a different group health plan. Both of these approaches appears permissible under the New Guidance.

If a participant in an integrated HRA loses group health coverage, the participant can still use the amounts remaining in the HRA, and the HRA will still be considered PPACA-compliant.

The New Guidance clarifies that, notwithstanding the above requirements that apply to integrated HRAs, 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 loses coverage under the group health plan coverage, without causing the HRA to fail to comply with the market reforms.

Comment: Plan sponsors should keep in mind that because HRA coverage generally qualifies as "minimum essential coverage" for any month in which a former employee is "enrolled" (i.e., able to reimburse a medical expense), a former employee's continued access to his or her HRA balance would result in such former employee being enrolled in "minimum essential coverage" – which, in turn, would make them ineligible for premium subsidies and cost-sharing reductions with respect to Exchange-based coverage.

A question left unanswered by the New Guidance is whether this rule could be used by an employer to fund individual health insurance policies for its employees through an HRA by establishing an integrated HRA, and then terminating the group health coverage. We expect further guidance may clarify whether this approach would be permissible.[4]

However, the New Guidance does not address how amounts credited or made available under non-integrated HRAs prior to January 1, 2014, will be treated. Additional guidance may be forthcoming on this issue.

When the Agencies released FAQ 11 in January 2013 (see Footnote 2), they specifically stated it was anticipated that future guidance would provide that, regardless of whether an HRA was integrated with other group health plan coverage, unused amounts credited before January 1, 2014 could be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the PPACA market reforms. However, the New Guidance does not address this issue.

Comment: Many employers currently have employees with balances in their HRAs that have accumulated over the past years, and those employees were not participating in group health coverage, so they have existing non-integrated HRAs. The New Guidance provides that 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 after the employee loses integrated group health plan coverage, but does not address if employees can use amounts that were credited prior to the effective date of the PPACA market reform requirements (January 1, 2014) under an HRA that was never integrated with group health plan coverage. Our understanding is that the Agencies are aware that this issue is still unresolved, and that further guidance specifically addressing this issue is under consideration.

A retiree-only HRA will be considered to be minimum essential coverage for purposes of PPACA.

The New Guidance provides that stand-alone retiree-only HRAs constitute eligible employer-sponsored plans, and therefore the coverage constitutes "minimum essential coverage for any month in which ***any*** funds are retained in the HRA – including amounts retained in the HRA after the employer has ceased making contributions. Individuals are not eligible for premium tax credits if they are receiving minimum essential coverage through an employer-sponsored plan, and, as a result, pre-age 65 retirees[5] covered by such an HRA will not be eligible for the premium tax credit for any month in which the HRA retains any funds.

Comment: This guidance limits the utility of retiree-only HRAs, which some employers had envisioned using to assist pre-65 retirees in purchasing Exchange coverage. By making retirees covered by these HRAs ineligible for the premium tax credit, the Agencies have made many low-balance HRAs unattractive to retirees, because their eligibility for PPACA's premium tax credit would likely be of greater value than any benefit they could receive under a low-balance HRA. Hence, it appears that stand-alone retiree-only HRAs will become less popular in light of this guidance.

Although unclear, it appears that employers may be able to provide retirees with an annual enrollment option under which a retiree could choose whether to have coverage (i.e., receive reimbursements) under the retiree-only HRA plan for a given year. Additional guidance would be needed to determine if this would have the effect of preserving HRA account balances for use in future years, while at the same time ensuring that the retiree-only HRA does not render a retiree ineligible for premium subsidies for a given year as discussed in our comments above. As noted previously, the New Guidance states that an individual is ineligible for the subsidies for any month in which funds are "retained" in the HRA.

The New Guidance clarifies how integrated HRAs may be taken into account in determining the related medical plan's "minimum value" and "affordability."

The New Guidance makes a distinction between HRAs that are integrated with an employer's own major medical plan and a major medical plan offered by another employer (such as a plan sponsored by the employer of the employee's spouse).

Regarding the former, the New Guidance provides that if an employer offers an integrated HRA, the amounts newly made available under the HRA component may be taken into account in determining whether the employer's coverage satisfies either the affordability requirement or the minimum value requirement, but not both. However, if the amounts under the HRA may only be used to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan, then the HRA amounts may only count toward determining compliance with the minimum value requirement. If, however, the amounts under the HRA may be used to pay premiums, or both premiums and cost-sharing under the employer's primary (and integrated) plan, then the HRA amounts may only count toward determining the plan's affordability.

If an employer-sponsored HRA is considered integrated with a plan offered by another employer, the New Guidance provides that the HRA does not count toward the affordability or minimum value requirement of the plan offered by the other employer.

Comment: The New Guidance seems to generally support the utility of HRAs where integrated with an employer's own employer-sponsored plan. Although HRAs integrated with coverage offered by another employer are still permissible, they, of course, do not help either employer's coverage to satisfy the affordability or minimum value requirements. Hence, it appears that an HRA that can only be integrated with that employer's own major medical plan may provide more utility to the employer.

The New Guidance leaves unanswered whether an employer can sponsor an HRA in connection with HIPAA-excepted benefits.

As explained above, group health plans that provide only HIPAA-excepted benefits are generally not subject to the PPACA market reform requirements. It appears clear from the New Guidance that an HRA generally cannot be integrated with a group health plan that provides only HIPAA-excepted benefits under the integration tests set forth above. However, some employers have considered establishing HRAs that would, by their terms, be able to only reimburse claims related to HIPAA-excepted benefits, and provide those HRAs in conjunction with a group health plan that only covers HIPAA-excepted benefits. It is not clear whether this arrangement would be considered HIPAA-excepted by the Agencies and therefore not subject to the market reforms. Further guidance on this issue may be forthcoming.

Comment: It would seem to be the case that an HRA should be permitted if it is solely being utilized for purpose of reimbursing premiums in connection with HIPAA-excepted coverage. This is because such an arrangement would appear to be merely employer-paid HIPAA-excepted coverage, and in many respects could be accomplished via Code Section 105 without necessarily requiring the use of an HRA. However, based on the New Guidance, it seems that the Agencies may ultimately take the position that using an HRA to pay out-of-pocket expenses incurred with respect to HIPAA-excepted coverage is prohibited.

Employer Payment Plans (and Other Employer Healthcare Arrangements)

In addition to HRAs, the New Guidance applies, in part, to "certain other employer healthcare arrangements," including what the Agencies refer to as "employer payment plans." Employer payment plans, as defined in the New Guidance, are "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… or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee."

A longstanding IRS Revenue Ruling, Rev. Rul. 61-146, held that, if an employer reimburses an employee's premiums for non-employer sponsored medical insurance, the payments are excluded from the employee's gross income under the Code. (Note that an employer payment plan only includes amounts that are paid by the employer on a pre-tax basis, not an employer-sponsored arrangement under which an employee can use after-tax dollars toward health coverage).

While employer payment plans have historically been rather obscure vehicles for providing health coverage to employees, after the enactment of PPACA, some had thought that they could be a means for allowing employers to provide their employees with employer-sponsored coverage, while eliminating the need to provide an employer-sponsored group health plan (since employees would be required under the plan to purchase individual insurance policies). While Revenue Ruling 61-146 provided an argument that such arrangements would be subject to preferred tax treatment, left unanswered was whether such an arrangement would qualify as a "group health plan" for purposes of PPACA and, if so, whether employer payment plans would suffer from the same infirmities as stand-alone HRAs in their attempt to comply with PPACA's market reforms.

The New Guidance provides the following guidance regarding employer payment plans:

Similar to stand-alone HRAs, an employer payment plan cannot meet the requirements of PPACA, both because it cannot meet the annual and lifetime limit requirements, but also because it cannot meet the preventive care requirements.

The New Guidance clarifies that employer payment plans are not a viable means of providing employer-sponsored coverage under PPACA. This is because, similar to stand-alone HRAs, the New Guidance provides that an employer payment plan is a group health plan, but is not considered "integrated" with any individual insurance policy purchased under the arrangement.

Accordingly, the New Guidance provides that an employer payment plan is subject to PPACA's market reforms, but cannot meet the annual dollar limit because it effectively imposes an annual limit up to the cost of the individual market coverage purchased through the arrangement. The New Guidance also provides that an employer payment plan cannot meet the preventive care requirement because it does not provide preventive services without cost-sharing in all instances.

Comment: While the guidance specifically addresses employer payment plans, it appears clear that the guidance would similarly apply to any group health plan arrangement under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy.

The status of Code Section 125 premium-only plans (POPs) remains unclear under the New Guidance.

As noted above, the New Guidance provides that an employer payment plan is a group health plan and, as such, is subject to PPACA's market reforms. What is unclear, however, is whether an employer payment plan encompasses a POP, i.e., where the employer does not sponsor a group major medical plan but only sponsors a Code Section 125 plan for purposes of allowing a participant to pay for his or her individual insurance on a pre-tax basis through salary reduction.

As discussed above, an "employer payment plan" is defined in the New Guidance as a "group health plan[] under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy… or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee."

With respect to a POP, the employer does not agree to reimburse the employee for his or her premium cost. Rather, the employer only makes available access to a Code Section 125 plan for purposes of allowing a participant to pay for his or her individual insurance on a pre-tax basis via salary reduction. Thus, it seems there is a strong argument that a POP is not a group health plan and should not qualify as an "employer payment plan." However, for federal tax purposes, the amounts that are reduced from salary via a Code Section 125 plan (including POPs) are generally treated as employer contributions. Thus, it seems possible that the IRS could take the view that a POP is but a variant or type of "employer payment plan."

Comment: Whether a POP qualifies as an employer payment plan is of little relevance with respect to Exchange-based individual insurance. This is because, as discussed below, except for limited transition relief, effective for tax years beginning after December 31, 2013, employees who purchase individual insurance through the state or federally-facilitated marketplaces may not pay for such coverage on a pre-tax basis. Thus, the question seems most relevant to whether employers may permit employees to pre-tax premiums associated with their purchase of individual insurance other than through an Exchange.

Health Flexible Spending Arrangements (FSAs)

In general, a health FSA is any employee- or employer-funded account designed to reimburse employees for medical care expenses. They are typically funded by employee contributions through a salary reduction agreement, although employers can also contribute to FSAs on behalf of their employees. Contributions made to a health FSA offered through a Code Section 125 cafeteria plan do not result in gross income to the employee.

The New Guidance addresses certain outstanding issues with respect to how certain PPACA provisions apply to health FSAs. Specifically, the New Guidance addresses the application of the market reforms, including the prohibition on annual dollar limits and the preventive care requirement, to certain types of health FSAs. The New Guidance provides as follows:

A health FSA that provides only excepted benefits is not subject to PPACA's market reforms.

The New Guidance provides that a health FSA that provides only excepted benefits is not subject to the PPACA market reforms.[6] However, the New Guidance also makes clear that a health FSA that does *not* qualify as an excepted benefit is subject to the PPACA market reforms, including the prohibition on annual limits on essential health benefits and the preventive care rules.

Comment: The New Guidance notes that the interim final regulations regarding the annual dollar limit prohibition contain an exemption for health FSAs (as defined in Code Section 106(c)(2)). Questions have arisen regarding whether this exemption applies to a health FSA that is *not* offered through a Code Section 125 plan (such as an HRA or other arrangement funded principally through employer contributions), as would be permitted under the Code Section 106(c)(2) definition of an FSA. The New Guidance states that the Agencies "intended for this exemption from the annual dollar limit prohibition to apply only to a health FSA that is offered through a Code Section 125 plan and thus subject to a separate annual limitation under

Code Section 125(i), and that, "there is no similar limitation on a health FSA that is not part of a Code Section 125 plan, and thus no basis to imply that it is not subject to the annual dollar limit prohibition." The Agencies state that they intend to amend the annual dollar limit prohibition regulations retroactively as of September 13, 2013 to conform to this New Guidance. As a result, a health FSA that is not offered through a Code Section 125 plan is subject to the annual dollar limit prohibition, and as a result cannot comply with PPACA market reform requirements.

To the extent an employer fails to sponsor corresponding non-excepted benefits and/or comply with the coverage limits, the health FSA will *not* qualify as an excepted benefit and will become subject to the PPACA market reforms.

The New Guidance makes clear that if an employer's health FSA fails to qualify as an excepted benefit, it will be subject to PPACA's market reforms, including the preventive care requirement, as well as the prohibition on the use of annual dollar limits on essential health benefits.

As noted in footnote 6, a health FSA generally may qualify as an excepted benefit if other group health plan coverage not limited to excepted benefits is made available for the year to employees by the employer, but only if the arrangement is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). Thus, to the extent that: (i) an employer sponsors only a health FSA and not also non-excepted medical coverage; and/or (ii) the health FSA provides for coverage that exceeds two times the participant's salary deferral election (or, if greater, $500 plus the amount of such salary deferral), then a health FSA will not qualify as an excepted benefit and will become subject to PPACA's market reforms.

Comment: Given the defined contribution nature of health FSAs (with their maximum coverage amounts), it would seem to be the case that health FSAs that do not qualify as HIPAA-excepted benefits will be unable to satisfy the requisite market reforms and could result in material penalties to the plan sponsor under PPACA's market reform provisions. Accordingly, employers should review the coverage terms of their health FSAs and benefit plan offerings more generally to ensure that their health FSAs qualify as HIPAA-excepted.

Cafeteria Plans

IRC Section 125 cafeteria plans are the principal means by which an employee may pay for his or her share of employer-sponsored coverage on a pre-tax basis. This is accomplished by the employee making a salary reduction election under which he or she chooses to not receive taxable wages in favor of paying for his or her premium share with tax-free dollars that would otherwise be paid to him or her by the employer. Many questions have arisen regarding the ability of employees to pay for Exchange-based individual or small group insurance on a pre-tax basis through a cafeteria plan. The New Guidance helps clarify the rules that will apply beginning in 2014 and provides some helpful transition guidance for non-calendar year plans.

Effective for tax years beginning after December 31, 2013, employees are not permitted to pay for individual exchange-based insurance on a pre-tax basis through their employer's Code Section 125 cafeteria plan (except per the limited transition relief discussed below).

PPACA Section 1515 amended Code Section 125(f) to provide that, effective for tax years beginning after December 31, 2013, Exchange-based individual coverage may not be offered as a "qualified benefit" subject to the preferential tax treatment of Code Section 125. Put differently, employees who purchase individual insurance through the state or federally-facilitated marketplaces may not pay for that coverage on a pre-tax basis. (Please note that, per the discussion above, it appears that an employer also may not help subsidize on a tax-free or income-excludable basis a portion of the employee's cost of such insurance coverage.)

Comment: Since employees will not have access to an employer's cafeteria plan when purchasing individual Exchange-based insurance, this will have the effect of increasing the employee's effective cost for this coverage equal to their marginal tax rate. Thus, employers should be careful to communicate this fact to employees if they intend to educate employees about their coverage options in 2014. Please note that, to the extent a qualifying small employer sponsors group insurance through a SHOP Exchange, such coverage may be paid on a pre-tax basis through the employer's cafeteria plan.

The New Guidance provides limited transition relief for certain non-calendar year plans.

The Agencies recognize that some state Exchanges have already allowed employees to enroll in health coverage through the Exchange as a benefit under a Code Section 125 cafeteria plan, in spite of the change to Code Section 125(f)(3) discussed above. To account for the disconnect between the effective date of Code Section 125(f)(3) and non-calendar year Code Section 125 plans, the Agencies have provided limited narrow relief which allows for a short period of time (i.e., the remainder of a non-calendar year Code Section 125 plan's plan year that stretches into 2014) the purchase of Exchange coverage through a Code Section 125 plan as a qualified benefit. Exchange coverage purchased under this relief will not result in all benefits provided under the Code Section 125 plan being immediately taxable.

Comment: Although the New Guidance provides limited relief regarding the continued use of cafeteria plans, the New Guidance provides that any individuals who receive such benefits through a Code Section 125 plan shall be ineligible for Code Section 36B premium tax credits (and related cost-sharing reductions) for any period for which the individual utilizes the Code Section 125 plan relief.

The relief is only available to cafeteria plans that, as of September 13, 2013, operated on a non-calendar year basis. Hence, the relief is narrowly tailored to apply only to existing non-calendar year cafeteria plans.

Employee Assistance Programs (EAPs)

Employee assistance programs are welfare programs that provide employees with access to referral or counseling services for problems such as alcoholism, drug abuse, financial issues, or legal issues. The New Guidance also provides some limited guidance regarding the treatment of EAPs under PPACA, including with respect to certain market reforms as well as the ability of EAPs to qualify as "minimum essential coverage" for purposes of the individual shared responsibility provisions (i.e., the individual mandate) (and, impliedly, how the provision of EAPs effects eligibility for premium tax credits and cost-sharing reductions, and the employer shared responsibility provisions).

The New Guidance clarifies the circumstances under which EAPs are subject to PPACA market reforms.

The Agencies indicated that they will amend the existing federal regulations that currently define "excepted benefits" to include an EAP, if the EAP does not provide "significant benefits in the nature of medical care or treatment." Until that rulemaking is final, employers may use a reasonable, good faith interpretation of whether an EAP provides "significant benefits in the nature of medical care or treatment." If an EAP is considered excepted benefits, it will not be "minimum essential coverage" and the PPACA market reform requirements will not apply to the EAP.

Comment: Many, if not most, EAPs today provide counseling benefits, which the Agencies have previously informally indicated they would consider to be significant medical care or treatment. Hence, the broad and open-ended "reasonable, good faith interpretation" standard of this guidance is quite surprising and significant, in that it appears to leave open, at least for the time being, the issue of whether EAPs that provide counseling benefits will be providing significant medical care or treatment benefits.

It is likely that many employers with EAPs could conclude, in their own reasonable, good faith interpretation, that such counseling benefits are not sufficient to constitute "significant benefits in the nature of medical care or treatment," and hence conclude that their EAPs are excepted benefits. Whether the Agencies ultimately agree with this interpretation remains to be seen, but, under this guidance, such an interpretation would appear to be valid at least through 2014.

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[1] On September 16, 2013, the Centers for Medicare and Medicaid Services issued a memorandum indicating that it concurs with the sections of the guidance that are applicable to the Department of Health and Human Services. That memorandum is available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf

[2] *See* FAQs about Affordable Care Act Implementation Part XI, available at: http://www.dol.gov/ebsa/faqs/faq-aca11.html

[3] HIPAA-excepted benefits include such things as accident-only coverage, disability income, certain limited-scope dental and vision benefits, and certain long-term care benefits.

[4] Significant employer contributions to an HRA could also implicate PPACA's nondiscrimination requirements, which are not yet effective.

[5] Retirees over the age of 65 will generally be eligible for Medicare, and therefore will not be eligible for federal subsidies with respect to Exchange-based individual insurance.

[6] A health FSA is 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 the FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.