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Federal Guidance on HRAs, Health FSAs and Other Employer Funding Arrangements Under Health Care Reform

On September 13, 2013, the Internal Revenue Service, U.S. Department of Labor and U.S. Department of Health and Human Services, collectively, issued guidance (the "Health Funding Guidance") on the application of two of the market-based health care reforms under the Affordable Care Act ("ACA") to health reimbursement arrangements ("HRAs"), health flexible spending arrangements ("Health FSAs"), employer reimbursement plans and employee assistance programs ("EAPs"). The new guidance is effective for plan years of group health plans beginning on or after January 1, 2014.

Basics of the New Guidance

The new Health Funding Guidance will impact employer account-based health arrangements (HRAs, Health FSAs and employer reimbursement plans) and EAPs in the following ways starting with the plan year beginning in 2014:

- HRAs generally will need to limit coverage to employees enrolled in other group health plan coverage. Specific rules for the "integration" of HRA benefits with group health plan benefits will need to be met.
- Employer funding of Health FSA benefits will need to be limited to not more than the greater of $500 or the amount funded by the employee through pre-tax salary reduction elections.
- Employers will not be able to reimburse employee premiums for individual health insurance on a tax free basis without violating the new health care market reform rules.
- EAPs will generally still be permitted, so long as they do not provide significant medical care or treatment benefits.

These key elements from the Health Funding Guidance are discussed in greater detail below.

Applicable Market Reforms

The two market reforms addressed in the Health Funding Guidance are (i) the prohibition on establishing an annual limit on the dollar amount of benefits for any individual under a group health plan and (ii) the requirement that group health plans (other than a group health plan that is "grandfathered" under the ACA[1]) provide certain preventive health services without imposing any cost-sharing requirements for such services (collectively, the "Applicable Market Reforms").

Employer Account-Based Health Funding Arrangements

An HRA is an arrangement that is funded solely by an employer and reimburses, up to a maximum prescribed dollar amount on a pre-tax basis, an employee for medical care expenses incurred by the employee, the employee's spouse or dependents, or any of the employee's children who have not attained age 27 as of the end of the relevant taxable year. A Health FSA is a benefit arrangement that is funded by employer contributions or pre-tax employee

[1] A "grandfathered plan" under the ACA means generally a group health plan with at least one enrolled participant in effect on March 23, 2010, and which has continued in force but has not been substantially changed, as per applicable agency guidance, since that date.

salary reduction contributions, or both, and is designed to reimburse, on a tax-free basis, an employee for medical expenses (other than premiums) incurred by the employee, the employee's spouse or dependents, or any of the employee's children who have not attained age 27 by the end of the relevant taxable year. Health FSAs are most often maintained as part of an employer's Internal Revenue Code section 125 cafeteria plan. An employer reimbursement plan is an arrangement whereby an employer reimburses an employee for the premiums or other medical care expenses incurred in connection with hospital and medical insurance coverage that is not sponsored by the employer. Under current law, the premiums and expenses so paid by the employer, either as a reimbursement for amounts paid by an employee or directly to the insurance company, are excluded from the employee's income.

Impact of Applicable Market Reforms on Employer Health Funding Arrangements

The Applicable Market Reforms impact group health plans generally. HRAs, Health FSAs and employer reimbursement plans are group health plans and therefore are subject to the Applicable Market Reforms.[2] However, the Applicable Market Reforms do not apply to a group health plan for a plan year if, on the first day of the plan year, the group health plan has fewer than two participants who are current employees (a "retiree-only plan"). Further, if the group health plan provides solely "excepted benefits," it will be exempt from complying with the Applicable Market Reforms.[3]

Applicable Market Reforms and HRAs

Except for an HRA that qualifies as a retiree-only plan or offers only excepted benefits, an HRA will violate the Applicable Market Reforms unless, in accordance with the Health Funding Guidance, it is "integrated" with a group health plan that otherwise satisfies the Applicable Market Reforms. Thus, under the Health Funding Guidance, an HRA may not be integrated, for purposes of complying with the Applicable Market Reforms, with individual health insurance coverage, such as individual coverage obtained beginning in 2014 on the new health care exchanges or marketplaces, even if such individual market coverage meets the Applicable Market Reforms. Therefore, a non-integrated, or "stand-alone," HRA will violate the Applicable Market Reforms.

Integrated HRAs

The Health Funding Guidance prescribes two methods for effectively integrating an HRA with a group health plan for purposes of satisfying the Applicable Market Reforms. The requirements under each of these methods are generally the same. However, under one method where the related group health plan does not provide "minimum value" of benefits, the integrated HRA must be limited to reimbursement of one or more of the following expenses: co-payments, co-insurance, deductibles and premiums under the group health plan, as well as medical care that does not constitute essential health benefits.[4] The health care expenses that may be reimbursed under an HRA that is integrated with a related group health plan that satisfies the minimum value of benefits requirement are not so limited.

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[2] It is noted that, unless they constitute "excepted benefits," HRAs, Health FSAs and employer reimbursement plans constitute eligible employer-sponsored plans and therefore coverage under such arrangements can qualify as "minimum essential coverage." Thus, an individual covered under such a health funding arrangement (unless it qualifies as excepted benefits) will not be eligible for the government-funded cost-sharing subsidy for individual health coverage under the new health plan exchanges beginning in 2014.

[3] Excepted benefits include, among other things, accident-only coverage, disability income, certain limited-scope dental and vision benefits, and certain long-term care benefits.

[4] An employer-sponsored health plan provides "minimum value" of benefits if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs. The minimum value requirement is applicable generally in determining whether an individual may be eligible for government-provided cost-sharing subsidies toward the purchase of exchange-based health coverage.

To comply with either permissible integration method, in addition to the requirement regarding the types of expenses that may be reimbursed by the HRA: (i) the employer must offer a group health plan (other than the HRA) to employees that does not consist solely of excepted benefits (but that satisfies the Applicable Market Reforms), (ii) 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 employee's employer sponsors the non-HRA group health plan, (iii) the HRA is available only to employees who are enrolled in the non-HRA group health plan (regardless of whether the employee's employer sponsors the non-HRA group health plan, such as a non-HRA group health plan sponsored by the employer of the employee's spouse), and (iv) under the HRA's terms, the employee (or former employee) must be permitted to permanently opt-out of and waive future reimbursements from the HRA at least annually, and upon the employee's termination of employment, either the HRA balance is forfeited or the employee is afforded the right to permanently opt-out of and waive further HRA reimbursements. The opportunity to opt-out of and waive HRA benefits enables the employee to avoid the continued availability of HRA reimbursements as constituting ongoing group health plan coverage which prevents the employee from otherwise qualifying for exchange-based health coverage cost-sharing subsidies.

Health FSAs

The Applicable Market Reforms will not apply to a Health FSA if the employer also offers a group health plan that is not limited to the provision of excepted benefits and the terms of the Health FSA provide that the maximum annual Health FSA benefit available to any participant may not exceed two times the amount of the participant's salary reduction contribution election with respect to the Health FSA (or, if greater, the participant's salary reduction contribution election amount plus $500). If a Health FSA does not limit benefits in this way, it will fail to meet the market reform requirements.[5]

Employer Reimbursement Plans

Because an employer reimbursement plan may not be integrated with an employee's individual health insurance coverage, such a plan, by its design, will normally violate the Applicable Market Reforms. However, an employer reimbursement plan that qualifies as a retiree-only plan will be exempt from the Applicable Market Reforms and may continue to provide medical expense reimbursements on a pre-tax basis to such covered retirees. If an employer establishes a payroll practice of forwarding after-tax employee wages to a health insurance company at the employee's direction and without any substantial employer involvement in such process (*e.g.*, no employer contributions; employer simply collects and remits premiums through payroll reduction), such payroll practice will not create a group health plan, and thus the Applicable Market Reforms will not apply to such payroll premium forwarding arrangement. In addition, an employer will not create an employer reimbursement plan and thus will not violate the Applicable Market Reform if it establishes an arrangement that allows employees to choose between receiving cash or an after-tax amount that is applied toward health coverage.

Employee Assistance Programs

The Health Funding Guidance also provides that benefits under an EAP will not be subject to the Applicable Market Reforms if the EAP does not provide significant benefits in the nature of medical care or treatment. Until additional guidance is issued (but in no event before 2015), employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment.

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[5] Health FSAs provided under a Code section 125 cafeteria plan are subject to a separate dollar limit on the annual amount of employee salary reduction contributions to an employee's Health FSA ($2,500 for 2013, as adjusted for years after 2013).

Summary

The impact of the Applicable Market Reforms on HRAs, Health FSAs, employer reimbursement plans and EAPs, as provided in the Health Funding Guidance, is both complicated and significant, with a different analysis applying depending on the type of employer health funding arrangement involved. Failure to comply with the Applicable Market Reforms can result in the imposition of substantial excise tax penalties on the employer that maintains a non-compliant health funding arrangement (*i.e.*, $100 excise tax for each day the arrangement is non-compliant and for each individual to whom the non-compliance relates).

Generally, unless an HRA provides solely excepted benefits, is treated as a retiree-only plan, or is properly integrated with a market reform-compliant group health plan, as described above, an HRA will violate the Applicable Market Reforms. In addition, a Health FSA will violate the Applicable Market Reforms unless the employer also offers compliant group health plan coverage and the annual benefits available under the Health FSA to any participant is appropriately limited (*i.e.*, generally to two times the employee's annual salary reduction election amount with respect to the Health FSA). An employer reimbursement plan will also fail to satisfy the Applicable Market Reforms unless it qualifies as a retiree-only plan, an employer payroll practice providing taxable pay that is not treated as a group health plan, or only offers employees a choice between receiving cash or an after-tax payment toward health coverage. Lastly, an EAP may be structured to provide excepted benefits, and thus avoid compliance with the Applicable Market Reforms, if it is found not to provide significant benefits in the nature of medical care or treatment, a requirement that will likely be the subject of additional guidance.

Accordingly, we strongly recommend that employers review their current, as well as proposed, employer health funding arrangements to determine whether their structure enables the arrangement to comply with the Applicable Market Reforms, either through an exemption from such requirements (*e.g.*, plan providing solely excepted benefits or a retiree-only plan) or, in the case of HRAs, the integration of the HRA with a qualifying group health plan.

Should you have any questions or would like any assistance in understanding and implementing the Health Funding Guidance with respect to your health funding arrangements, please contact any of the attorneys listed below.

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