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Recent Government-Issued FAQs Clarify ACA Employer Mandate, Market Reforms

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Notice 2015-87 (the Notice) provides recent government guidance on the Affordable Care Act (ACA) employer mandate and market reforms. The Notice contains 26 frequently asked questions (FAQs) from the Internal Revenue Service (IRS) and U.S. Departments of Health and Human Services (HHS) and Labor (DOL) that address the following topics:

- The application of market reforms to health reimbursement arrangements and employer payment plans
- The affordability of employer-sponsored health coverage
- Hour-counting and penalties under the ACA employer mandate
- The application of COBRA continuation coverage rules and health flexible spending account carryovers
- Employer reporting relief
- Government entities, health savings accounts and benefits that the U.S. Department of Veterans Affairs administers

The Notice also contains special guidance on AmeriCorps members and government employers which we do not address below. While previous guidance addressed some of the issues discussed in the Notice, new notable topics for employers include:

Employer Payment Plans and Health Reimbursement Arrangements (HRAs)

- *Active-employee HRAs must be integrated*. Active-employee HRAs that are not "integrated" with a non-HRA group health plan (*e.g.,* HRAs allow amounts credited to the HRA to be used to purchase individual market coverage) cannot continue beyond their 2013 plan years unless their coverage is limited to excepted benefits, or they are otherwise exempt from the Public Health Service Act (PHSA) mandates (*e.g.*, retiree-only HRAs). A current-employee HRA that includes terms permitting the purchase of individual market coverage will constitute a group health plan that fails to meet the market reforms because it is not integrated with another group health plan. Regardless of whether HRAs are integrated with other group health plans, unused amounts credited before January 1, 2014, (including any amounts credited before January 1, 2013, and any amounts credited during 2013 under an HRA in effect on January 1, 2013) may be used after December 31, 2013, to reimburse medical expenses, while maintaining the HRA's compliance with preventive service requirements and the annual dollar limit prohibition. The Notice also confirmed that HRAs that cover fewer than two active employees (*e.g.*, retiree-only HRAs) are not subject to PHSA mandates and may continue.
- *Family HRA participants must enroll in other group coverage.* The Notice echoes prior guidance requiring current-employee HRAs to be "integrated" with a non-HRA group health plan that alone satisfies ACA market reforms after 2013. The Notice clarifies that, to be eligible for benefits under an integrated HRA, a covered employee's family members (*i.e.*, spouse and/or dependents) must be

enrolled in both the HRA and the employer's associated group health plan coverage. Because the IRS and the Department of Treasury recognize that many HRAs do not currently comply with this rule, they will not penalize family HRAs for family members not enrolled in group coverage for plan years beginning before January 1, 2016. In addition, they will not treat an HRA and group health plan that otherwise would be integrated based on the terms of the plan as of December 16, 2015, as failing to be integrated with an employer's other group health plan for plan years beginning before January 1, 2017, solely because the HRA covers expenses of one or more of an employee's family members even if those family members are not also enrolled in the employer's other group health plan.

- *HRAs or employer payment plans that only reimburse premiums for excepted benefits are in compliance*. Market reforms do not apply to group health plans designed to only provide excepted benefits (*e.g.*, dental coverage). Thus, HRAs or employer-payment plans that permit reimbursement or direct payment of premiums for individual market coverage (if that individual market coverage covers only excepted benefits) does not fail to comply with the market reforms.
- *Limitations on employer payment plans*. An employer payment plan is an arrangement that pays or reimburses an employee's cost of individual health insurance coverage. The Notice clarifies that an employer payment plan offered through a cafeteria plan is considered a group health plan. As such, it cannot reimburse or pay for premiums for individual market coverage (other than coverage only for excepted benefits). In addition, employer payment plans cannot be integrated with individual market coverage in order to satisfy ACA market reforms, such as the annual dollar limit prohibition and preventive service requirements. This restriction applies regardless of whether the employer payment plan is funded through salary reductions or through employer contributions, such as flex credits.

Affordability of Employer Coverage

- *Affordability threshold for 2015 and 2016*. Under the ACA safe harbor test, a larger employer's health coverage is considered affordable if the employee's required contribution toward individual-only plan premiums does not exceed 9.5 percent of the employee's household income for the year. The Notice states that the 9.5 percent affordability threshold will be adjusted annually for inflation. For plan years beginning in 2015, employers may use the 9.56 percent threshold, and for plan years beginning in 2016, they may use the 9.66 percent threshold.
- *Certain HRA amounts count toward "affordability" determination*. Employer contributions to an integrated HRA that can be applied toward the employee cost coverage under the employer's medical plan may be factored into the determination of affordability under the ACA's employer shared responsibility rule. The amount of the employer's HRA contribution must either be required under the terms of the HRA or determined in a reasonable time before an employee must enroll in the eligible employer-sponsored plan. The HRA may permit the use of HRA funds to pay for other health expenses, such as cost-sharing or vision or dental premiums, in addition to employer medical plan premiums. For example, if an employer contributes $1,200 to an integrated HRA for a plan year, the employee's required contribution for coverage under the employer's medical plan is reduced by $100 per month (1/12 of the annual employer contribution per month) whether or not the employee actually uses the HRA to pay for medical plan premiums.
- *Employer flex contributions may also affect affordability*. Employer flex contributions through a Section 125 cafeteria plan can reduce the employee's required contribution toward the cost of employer medical coverage only if the amount is a "health flex contribution." To qualify as a health flex contribution, (1) an employee may not choose to receive the amount as a taxable benefit, (2) an employee may use the amount to pay for minimum essential coverage, and (3) an employee may use the amount solely to pay for medical care. For plan years starting before January 1, 2017, employer flex contributions that are not health flex contributions because they may be used for non-health benefits (including non-taxable benefits and/or cash or another taxable benefit), but that may also be used toward the amount the employee otherwise must pay for health coverage, may be factored into the employer's affordability analysis. This is only true for flex contribution arrangements that were adopted by December 16, 2015,

and did not substantially increase their amount of flex contributions after December 16, 2015. The IRS recommends that employers report employee costs without reducing employee-required contributions due to flex credit contributions. In addition, solely for coverage for plan years beginning before January 1, 2017, an employer may reduce the amount of the employee's required contribution by the amount of a non-health flex contribution (other than a flex contribution made under a non-relief-eligible flex contribution arrangement) for purposes of information reporting under line 15 of Form 1095-C. If the IRS were to examine the affordability of coverage for an employee based on a higher reported cost, an employer could address the availability of flex credits under this transition relief on appeal.

- *Opt-out payments may influence affordability*. An unconditional opt-out payment is additional taxable compensation paid to an employee solely because the employee waives coverage under the employer's group health plan. Treasury and the IRS reason that an unconditional opt-out payment effectively increases the employee's contribution for health coverage. For example, if an employer requires employees who elect individual-only coverage to contribute $200 per month toward coverage, and provides an unconditional opt-out payment (*i.e.*, not conditioned on the employee demonstrating other group coverage) of $100 per month, the actual amount of the employee's contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction. As a result, the employer must treat the opt-out payment in the same manner as a salary reduction for purposes of determining an employee's required contribution under §§ 36B and 5000A and any related consequences under § 4980H(b), which in this case is $300 per month.

  Treasury and the IRS intend to propose regulations requiring this inclusion of opt-out payments in the affordability calculation, predicting that regulations would require the inclusion of unconditional opt-out payments adopted or modified after December 16, 2015. Before the final regulations go into effect, the IRS will not require employers to report opt-out payments as increasing the employee's required contribution. Treasury and the IRS also anticipate that mandatory inclusion in the employee's required contribution of amounts offered or provided under an unconditional opt-out arrangement that is adopted after December 16, 2015, will apply for periods after December 16, 2015. For this purpose, an opt-out arrangement will be treated as adopted after December 16, 2015, unless (1) the employer offered the opt-out arrangement (or a substantially similar opt-out arrangement) with respect to health coverage provided for a plan year including December 16, 2015; (2) a board, committee or similar body or an authorized officer of the employer specifically adopted the opt-out arrangement before December 16, 2015; or (3) the employer had provided written communications to employees on or before December 16, 2015, indicating that the opt-out arrangement would be offered to employees at some time in the future.

  A conditional opt-out is treated differently. With respect to any participant who could demonstrate that the participant meets a condition (in addition to declining the employer's health coverage) that must be satisfied to receive an opt-out payment (*e.g.*, such as demonstrating that the employee has coverage under a spouse's group health plan), the participant may (versus must) treat the opt-out payment as increasing the employee's required contribution for purposes of §§ 36B and 5000A.

- *Employer fringe benefit payments under the Service Contract Act and the Davis-Bacon Act reduce the employee's required contribution*. The Service Contract Act and the Davis-Bacon and Related Acts (SCA/DBRA) require employees working on certain federal contracts to receive fringe benefits. An employer can generally satisfy its fringe benefit obligations by providing a particular benefit or benefits, as determined by the employer, that have a sufficient dollar value. Treasury and IRS continue to consider how the requirements of the SCA, the DBRA and the employer-shared responsibility provisions under § 4980H may be coordinated. For plan years beginning before January 1, 2017, these fringe benefits, including flex credits or flex contributions that are available to employees covered by the SCA or DBRA to pay for coverage under an eligible employer-sponsored plan (even if alternatively available to the employee in other benefits or cash), shall

reduce the employee's required contribution to the plan for purposes of § 4980H(b), but only to the extent the payment amount does not exceed the amount required to satisfy the SCA/DBRA requirements to provide fringe benefit payments. During this same period, employers may report that these fringe benefit payments reduce the cost of the employee's contribution. Employers are, however, encouraged to treat these fringe benefit payments as not reducing the employee's required contribution for purposes of reporting under §6056. If an employee's required contribution is reported without reduction for the amount of the fringe benefit payment and the employer is contacted by the IRS concerning a potential assessable payment under § 4980H(b) relating to the employee's receipt of a premium tax credit, the employer will have an opportunity to respond and show that it is entitled to the relief described in the Notice.

Employer Mandate

- *Employer mandate penalty is adjusted for inflation*. The employer mandate penalty was initially set at $2,000 per full-time employee for failure to offer employees coverage and $3,000 per full-time employee for failure to offer employees affordable minimum value coverage. These amounts are adjusted for inflation starting with 2015, when the adjusted penalty amounts are $2,080 and $3,120. For 2016, the adjusted penalty amounts are $2,160 and $3,240.
- *Counting "hour of service" when an employee is not working*. For determining full-time status under the ACA employer mandate, the Notice clarifies that an hour of service does not include any hours after the individual terminates employment with the employer. In addition, an hour of service does not include (1) an hour for which an employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed if such payment is made or due under a plan maintained solely for the purpose of complying with applicable workmen's compensation, or unemployment or disability insurance laws; and (2) an hour of service for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee. There is no 501-hour cap on the number of hours that may be credited to an employee while the employee performs no duties if the hours of service would otherwise qualify as hours of service (specifically, the 501-hour limit under hour-counting rules applicable to qualified retirement plans does not apply for this purpose).

  As to the source of the payments, hours of service for which no duties are performed include payments that an employer has made directly or indirectly (*e.g.*, through a trust fund or insurer that the employer contributes or pays premiums), and regardless of whether contributions made or due to the trust fund, insurer or other entity are for the benefit of particular employees or are on behalf of a group of employee in the aggregate. Hours of service include payments from a disability insurer, unless the employee paid with after-tax contributions so that the benefits received are treated as an arrangement to which the employer did not contribute. Finally, hours of service do not include worker's compensation or disability payments. Treasury and IRS intend to include these clarifications as proposed regulations under § 4980H effective as of December 16, 2015.

- *Offering TRICARE is offering minimum essential coverage*. Employers will be considered to have offered minimum essential coverage to employees for the months in which the employment with that employer results in eligibility for TRICARE.
- *Health Savings Account (HSA) eligibility for VA benefits recipients*. An individual actually receiving medical benefits from the VA is permitted to make HSA contributions if the medical benefits consist solely of (1) disregarded coverage, (2) preventive care or (3) hospital care or medical services under any law administered by the Secretary of Veterans Affairs for service-connected disability (within the meaning of § 101(16) of title 38, United States Code).

Health FSA Carryovers

- *Qualified beneficiaries may receive health FSA carryovers*. If a health Flexible Spending Account (FSA) permits carryovers (up to $500 in unused amounts remaining in a health FSA at the end of a plan year), any carryover amount must be included in determining a qualified beneficiary's benefit for the remainder of the plan year in which a qualifying event occurred. For example, if an employee has elected to reduce his or her salary by

$2,500 for the year and has carried over $500 in unused benefits from the prior year, the maximum benefit that the employee can become entitled to receive under the health FSA for the entire year is $3,000. If the employee experiences a qualifying event after submitting only $1,100 of reimbursable expenses under the health FSA, the employee would be entitled to a maximum benefit of $1,900 ($3,000 minus $1,100) if the employee elects to continue coverage under COBRA.

- *Health FSA COBRA continuation coverage charge excludes carryovers*. Although the carryover amount must be included in determining the maximum COBRA benefit, a group health plan may not take the carryover amount into account in determining the applicable COBRA premium. The COBRA premium may be based only on the sum of the annual employee's salary reduction election and the non-elective employer contribution, if any, for that plan year.
- *Health FSAs that allow carryovers must allow them for similarly situated COBRA and non-COBRA beneficiaries*. A health FSA must treat similarly situated COBRA and non-COBRA beneficiaries equally regarding carryovers. Therefore, if a health FSA permits ongoing employees to continue to spend-down a carryover amount after the end of a plan year, the same rights must be made available to COBRA-qualified beneficiaries, even though this could extend the COBRA-qualified beneficiary's coverage beyond the end of the calendar year of termination. The health FSA is not required to allow a COBRA beneficiary to elect additional salary reduction amounts for the carryover period and may not charge a COBRA premium for periods after the end of the plan year that includes the qualifying event. The plan must make the carryover amount available for the maximum period of COBRA continuation coverage under standard COBRA rules (*e.g.*, 18 months for a termination of employment or reduction in hours).
- *Health FSAs may condition carryovers on participation in the subsequent year*. Health FSAs may limit access to carryovers only to individuals who have elected to participate in the health FSA in the subsequent year. This applies even if participation in the subsequent year requires the participant to make a minimum salary reduction election. The Notice does not address whether this type of requirement could be used to limit the availability of carryovers to COBRA-qualified beneficiaries beyond the end of the calendar year that includes the qualifying event.
- *Health FSAs may limit carryovers to a maximum period*. Health FSAs may limit the availability of carryovers to a maximum period of time, such as one year. In that case, a participant who carried over a maximum $500 health FSA balance to a subsequent year but failed to elect additional amounts for the next year would forfeit the remaining amount at the end of that next year.

Next Steps

The IRS, HHS and DOL expect to issue additional rules to clarify ACA provisions.

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