SEYFARTH SHAW

Health Care Reform Management Alert Series

Agencies Issue ACA Guidance on Individual Account Plans and EAPs

Issue 73

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This is the seventy-third issue in our health care reform series of alerts for employers on selected topics in health care reform. (Our general summary of health care reform and other issues in this series can be accessed by clicking here.) This series of Health Care Reform Management Alerts is designed to provide a more in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Internal Revenue Service (IRS) and Department of Labor (DOL) recently issued guidance regarding various types of employer-provided account-based health care programs under the Affordable Care Act (ACA). Both the IRS and DOL issued guidance further describing the treatment of health reimbursement arrangements (HRAs), health care flexible spending accounts (Health FSAs), and employee assistance programs (EAPs) under the ACA. IRS Notice 2013-54, can be found *here*, and DOL Technical Release 2013-03 can be found *here*. The agencies state that their guidance is effective for plan years beginning in 2014 and later, but taxpayers may rely on the guidance for all prior periods. Also, in Notice 2013-57, found *here*, the IRS clarified the treatment of preventive coverage as defined under the ACA for purposes of Health Savings Account (HSA) eligibility. See our previous Alerts *46*, *52* and *53* in this series for background information on essential health benefits, annual limits and preventive care under the ACA.

[X] Applies to grandfathered plans

[X] Applies to non-grandfathered plans

Health Reimbursement Arrangements

The Notices provide clarifying guidance on several different plan designs involving HRAs.

A. HRA and Employer Payment Plans Compliance with Annual Limit and Preventive Care Reforms

As group health plans, HRAs are subject to the market reforms under the ACA, including the prohibition on annual limits on "essential health benefits" and the requirement that certain preventive services be provided without cost-sharing (first-dollar coverage). An HRA is, by definition, a limited amount of funds that can be used to pay for medical care, including essential health benefits. Prior *guidance* had already stated that an HRA which is integrated with a group health plan that satisfies

the prohibition on annual limits will also comply. The Agencies expanded this relief to provide that such an integrated HRA also will comply with the preventive services requirements if the group health plan with which the HRA is integrated so complies.

However, the Agencies cautioned that an HRA may not be integrated with a plan on the individual market to allow it to comply with either the annual dollar limit prohibition or the requirement for first dollar coverage of preventive services.

Similarly, an arrangement under which an employer reimburses employees for substantiated individual insurance policy premiums is a group health plan, which cannot be integrated with any individual health insurance policy purchased under the arrangement. As a result, it will not satisfy the annual limit prohibitions because the employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement and does not satisfy the preventive care requirements because it may not be able to provide first dollar coverage for preventive care in all instances. As a result, reimbursing employees for their purchase of health coverage elsewhere, such as on an Exchange, or paying for that coverage directly in place of sponsoring a group health plan will be problematic under the ACA.

B. Integration of an HRA with a Group Health Plan

The new guidance elaborated on how an HRA may be integrated with a group health plan, giving two methods as described below:

Method A Minimum Value Not Required	Method B Minimum Value Required
1. Employer offers a group health plan (in addition to the HRA) that does not consist solely of excepted benefits	1. Employer offers a group health plan (in addition to the HRA) that provides minimum value
2. Employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits	2. Employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that provides minimum value
3. The HRA is available only to employees who are enrolled in the non-HRA group coverage	3. The HRA is available only to employees who are enrolled in the non-HRA group coverage providing minimum value
4. The employee must be permitted to opt out 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 opt out and waive future reimbursements	4. The employee must be permitted to opt out 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 opt out and waive future reimbursements
5. The HRA is limited to reimbursement of one or more of the following: co-payments, co-insurance, deductibles and premiums under the non-HRA group coverage, plus medical care that does not constitute "essential health benefits"	

Note, for purposes of requirements 2 and 3, a different employer could sponsor the group health plan. But, if it is an employer outside of the controlled group, for example the spouse's employer, then the employee should certify to such coverage. Requirement 4 is necessary because the benefits under the HRA will constitute minimum essential coverage which will preclude the individual from claiming a premium tax credit on an Exchange. The annual enrollment window utilized by most plan sponsors should satisfy this requirement. Requirement 5 is present because if coverage was available for essential health benefits, there would be an annual limit on those (i.e., the balance in the HRA). The guidance specifically calls out this issue in its own Q&A, stating that if an HRA is available to cover a category of essential health benefits that are not covered by the integrated plan, there will be an annual limit violation.

What About Existing HRA Balances?

If an employer discontinues its HRA program or the employee ceases to be covered under the plan that is integrated with the HRA, the guidance confirms that contributions made to the HRA while it was integrated with a group health plan can still be used for medical expenses under the terms of the HRA and will not be considered to have violated the annual limit prohibitions or the first dollar preventive care requirements.

C. Retiree-only HRAs

Benefits that are "excepted benefits" under HIPAA are not subject to the market reforms enacted under the ACA. Excepted benefits include limited scope dental and vision benefits, plans covering fewer than two active employees, and certain health FSAs, as described below. While an HRA with fewer than two participants who are active employees (such as a retiree-only HRA) is not subject to the ACA's market reforms, the new guidance states that it is minimum essential coverage provided by an employer which would make a covered retiree ineligible for premium tax credits to help pay for coverage on an Exchange. Accordingly, employers may wish to inform retirees of this in communications describing the HRA.

D. HRA Contributions Can Apply to Affordability and Minimum Value Calculations

Prior guidance had provided that if an employer offers an employee both a primary eligible employer-sponsored plan and an HRA that would be integrated with the primary plan if the employee enrolled in the plan, amounts newly made available for the current year under the HRA may be considered in determining whether the arrangement satisfies either the affordability requirement or the minimum value requirement, but not both. The new guidance provides a bit more detail. Amounts that may be used only to reduce cost-sharing for medical expenses under the primary plan count only toward minimum value. Amounts that may be used to pay premiums and/or cost sharing, may only be used toward the affordability requirement.

Health Care Flexible Spending Arrangements

The market reforms of the ACA do not apply to a group health plan that provides only excepted benefits. Although health FSAs are group health plans, certain health FSAs are excepted benefits and therefore are not subject to the market reforms. These include health FSAs where (A) the account balance cannot exceed two times the participant's salary reduction election or (if greater) $500 plus the amount of the participant's salary reduction election, and (B) the employer also makes group health plan coverage available that is not limited to excepted benefits. (Health FSAs to which employers do not contribute should automatically satisfy the limit above.) A plan design structure that offers all employees participation in the health FSA, but only offers major medical benefits to full-time employees would appear no longer feasible next year. This is because the FSAs offered to the part-time employees would not satisfy the definition of an excepted benefit and, therefore, the market reforms would apply. These health FSAs would not satisfy the preventive care and annual limit requirements.

The guidance also states that the agencies are considering whether or not an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition.

Employee Assistance Programs

The guidance also addressed the application of the ACA's market reforms to EAPs, providing some relief. They state that EAPs will be considered an excepted benefits (and therefore not subject to the ACA's market reforms) if the EAP does not provide "significant benefits in the nature of medical care or treatment." They intend to amend the regulations to set forth this standard. But, until further guidance is issued, and at least through 2014, employers are to use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care of treatment.

Health Savings Accounts

In order to be eligible to make pre-tax contributions to an HSA, an individual must be covered by a high-deductible health plan (HDHP) and have no other health coverage that provides benefits before the HDHP deductible is satisfied. The Internal Revenue Code already contains a safe harbor permitting an HDHP to provide preventive care services below the deductible, which was defined by the IRS for this purpose in 2004. However, that definition of preventive care did not line up neatly with the ACA's definition. In this recent Notice, the IRS tries to fix this problem by providing that preventive care under the ACA also constitutes preventive care for purposes of the HDHP safe harbor.

Action Items

- Employers offering HRAs to current employees should make sure the HRAs can be integrated with their primary medical plan.
- Review the medical benefits offered under the EAP and consider whether they are significant.
- Verify that the health care FSAs satisfy the criteria to be an excepted benefit.
- Inform retirees in HRAs that the program may impact their ability to be eligible for a premium tax credit on the Exchanges

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