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New Guidance Clarifies Health Reimbursement Arrangements Under Affordable Care Act (ACA)

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Recently issued guidance clarifies the application of certain provisions under the **Affordable Care Act** (**ACA**) to health reimbursement arrangements, employer payment plans, health flexible spending arrangements and employee assistance programs.

The Affordable Care Act (ACA) includes certain market reforms that apply to group health plans. These market reforms include a prohibition on annual limits on the plan's essential health benefits (annual dollar limit prohibition), and the requirement for non-grandfathered plans to provide certain preventive care services without imposing cost-sharing requirements on those services (preventive services requirements). On September 13, 2013, the U.S. Department of the Treasury and the U.S. Department of Labor released guidance (Guidance) clarifying the application of these market reforms to (1) health reimbursement arrangements (HRAs), including HRAs integrated with a group health plan; (2) employer payment plans; (3) health flexible spending arrangements (Health FSAs); and (4) employee assistance programs (EAPs). The Guidance applies for plan years beginning on or after January 1, 2014, and may be applied for all prior periods.

HRAs

HRAs are funded solely by an employer and are designed to reimburse the employee and his or her eligible dependents' medical expenses. An HRA can be (but is not required to be) provided alongside another type of coverage.

Stand-Alone HRAs

In the case of a stand-alone HRA (one that is not integrated with another type of coverage), the Guidance provides that an HRA is a group health plan subject to the annual dollar limit prohibition and the preventive services requirements. Since HRA benefits are limited to the dollars within the HRA, and HRAs do not provide preventive care services without cost-sharing in all instances, a stand-alone HRA cannot comply with the annual dollar limit prohibition or preventive services requirements as required by the ACA. In addition, the Guidance confirms that for purposes of satisfying the annual dollar limit prohibition and preventive services requirements, stand-alone HRAs cannot be integrated with individual market coverage purchased using the HRA. Thus, a stand-alone HRA for active employees will fail to meet the ACA requirements. A retiree-only HRA can exist as a stand-alone

HRA.

If an HRA is integrated with another type of coverage as part of a group health plan, and the other coverage alone complies with the preventive services requirements, the combined HRA and coverage satisfies the preventive services requirements, regardless of the fact that the HRA alone does not satisfy the requirement. However, if an HRA is integrated with other coverage as part of a group health plan, and the other coverage alone complies with the annual dollar limit prohibition, the two do not necessarily satisfy the annual dollar limit prohibition.

The Guidance does, however, provide rules for determining when an HRA can be integrated with other coverage as part of a group health plan for purposes of the annual dollar limit prohibition. An HRA will be integrated with other group health plan coverage for this purpose if the HRA meets the Minimum Value Not Required Integration Method or the Minimum Value Required Integration Method. The Guidance does specify that the HRA and the coverage with which it is integrated are not required to share the same plan sponsor or governing documents, or to file a single Form 5500, in order to comply with either integration method.

Minimum Value Not Required Integration Method

Under the Minimum Value Not Required Integration Method, an HRA is integrated for purposes of the annual dollar limit prohibition if the following conditions are satisfied:

- The employer offers a group health plan in addition to the HRA that does not consist solely of excepted benefits;
- The employee receiving the HRA is actually enrolled in any group health plan other than the HRA that does not consist solely of excepted benefits (non-HRA coverage);
- The HRA is available only to employees enrolled in non-HRA coverage, regardless of whether the employer sponsors the non-HRA coverage;
- The HRA is limited to reimbursement of co-payments, co-insurance, deductibles and premiums under the non-HRA coverage, as well as medical care that is not essential health benefits; and
- Under the HRA terms, an employee may permanently 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 may permanently opt out of and waive future reimbursements from the HRA.

Minimum Value Required Integration Method

Under the Minimum Value Required Integration Method, an HRA is integrated for purposes of the annual dollar limit prohibition if the following conditions are satisfied:

- The employer offers a group health plan that provides “minimum value” under Internal Revenue Code (Code) Section 36B(c)(2)(C)(ii);
- The employee receiving the HRA is actually enrolled in any group health plan that provides

such minimum value (non-HRA MV coverage);

- The HRA is available only to employees enrolled in non-HRA MV coverage, regardless of whether the employer sponsors the non-HRA MV coverage; and

- Under the HRA terms, an employee may permanently 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 may permanently opt-out of and waive future reimbursements from the HRA.

Determining Affordability and Minimum Value

Amounts newly made available under an HRA for a plan year are able to count towards determining whether the coverage meets the affordability or minimum value requirements in the following circumstances:

- If an employer offers an employee both a primary eligible employer-sponsored plan and an HRA that would be integrated with the primary plan, and the employee enrolls in the plan, the HRA amounts newly made available for the current plan year may be considered in determining whether the arrangement satisfies either the affordability requirement or the minimum value requirement, but not both;

- Newly made available HRA amounts, for the current plan year, which can only be used by the employee to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan, may be considered for meeting the minimum value requirement; and

- Newly made available HRA amounts, for the current plan year, which an employee may use to pay premiums or to pay both premiums and cost-sharing under the primary employer-sponsored plan, may be considered for meeting the affordability requirement.

Amounts newly made available under an HRA for a plan year do not count towards determining whether the coverage meets the affordability or minimum value requirements in the following circumstances:

- HRAs integrated with a plan offered by another employer for purposes of the annual dollar limit prohibition or the preventive services requirements will not count toward the affordability or minimum value requirement of the plan offered by the other employer; and

- If an employer offers an HRA on the condition that the employee does not enroll in non-HRA coverage offered by the employer and instead enrolls in non-HRA coverage from a different source, the HRA does not count in determining whether the employer’s non-HRA coverage satisfies either the affordability or minimum value requirement.

Code Section 125 Plans

The Guidance clarifies that an employee may not purchase Exchange coverage through an employer’s Code Section 125 plan.

Health FSAs

Similar to an HRA, a stand-alone health FSA will not meet the annual dollar limit prohibition or preventive services requirements as required by the ACA. An employer may still offer a health FSA as long as the health FSA covers excepted benefits.

Employer Payment Plans

The Guidance clarifies that an employer may not reimburse an employee for some or all of the employee's Exchange premiums, or purchase Exchange-based coverage for an employee on a tax-favorable basis.

EAPs

The Guidance provides that benefits offered under an EAP are considered excepted benefits not subject to the ACA market reforms, as long as the EAP does not provide significant benefits in the nature of medical care or treatment. Until rulemaking is finalized, plan sponsors are allowed to use a reasonable good-faith interpretation of whether an EAP provides significant medical care or treatment benefits.

Next Steps

Employers sponsoring HRAs, employer payment plans or similar arrangements, Health FSAs or EAPs should review the structure of these benefits to ensure compliance with the ACA, applying the Guidance. Sponsors of HRAs also should determine whether the HRA can be integrated with another group health plan for purposes of compliance with the annual dollar limit prohibition and preventive services requirements.

Excise taxes and self-reporting requirements under Section 4980D of the Code are applicable for failure to comply with the ACA market reforms, including the annual dollar limit prohibition and preventive services requirements.

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