EMPLOYERS COUNCIL
ON FLEXIBLE COMPENSATION

1444 I Street NW, Suite 700 ◆ Washington, DC 20005 ◆ www.ecfc.org ◆ 202-659-4300 *Main* ◆ 202-216-9646 *Fax*

EMPLOYER ALERT
Individual Medical Policy Arrangements May Result in Significant Excise Tax Liability

The Employers Council on Flexible Compensation (ECFC) is an industry association made up of leading cafeteria and related benefit plan service providers and plan sponsors. In the aftermath of agency guidance (outlined below), ECFC has received numerous inquiries from employer plan sponsors and member companies as to whether employers can make available individual major medical coverage to employees on a tax-free basis as part of an employer-sponsored arrangement. This practice may have significant adverse tax consequences for employer plan sponsors. This Employer Alert Bulletin is intended to direct employers (and their counsel) to authoritative guidance on the issue.

As recently reported in ECFC's article titled "Agency Guidance Prohibits Pre-Tax Funding of Individual Medical Coverage For Active Employees" (linked here and attached as Appendix A) (the "ECFC Article"), the Department of Treasury and the Department of Labor (DOL) issued guidance that affects employers' ability to pay for individual market (IM) policies, (*i.e.*, major medical coverage that is subject to the Affordable Care Act (ACA))[1] through a cafeteria plan (the "Agency Guidance").

The ECFC Article provides that IRS Notice 2013-54 and related sub-regulatory guidance make it clear that a violation of the ACA would arise (resulting in the imposition of an excise tax against employers) due to any pre-tax funding of individual major medical (IM) coverage for active employees through a cafeteria plan. The Agency Guidance clearly provides that an employer's payment (or reimbursement) of IM premiums for employees violates the ACA and may result in a $100 per employee per day excise tax.

Beware of Entities Promoting Pre-Tax Arrangements to Reimburse or Pay for Individual Health Coverage

Despite the Agency Guidance, ECFC has continued to receive numerous inquiries based on the alleged position of some in the industry that the pre-tax payment of IM coverage premiums by an employer ***through a cafeteria plan*** remains a viable benefit option. One of the vendors' primary assertions is that payment of IM policy premiums through a cafeteria plan is not prohibited by the Agency Guidance because the cafeteria plan is not a group health plan subject to the ACA.

We agree that the payment of IM policy premiums is a permissible cafeteria plan qualified benefit and that the provision of such coverage through the cafeteria plan continues to be exempt from income and employment tax under the Internal Revenue Code. We also agree that a cafeteria plan, in and of itself, is not a group health plan subject to the ACA. However, the Agency Guidance clearly states that *any* arrangement, which pays or reimburses an employee's IM policy premiums on a pre-tax basis would be an "employer payment plan," which the Agency Guidance clearly indicates is a "group health plan" subject to the ACA. The Agency Guidance is also clear that an employer payment plan violates the ACA and employers who sponsor such arrangements would be subject to a potential *excise* tax of $100 per employee per day. *See the ECFC Article–Practice Pointer on page 2, the second entry in the table on page 3, and Section IV.A. on pages 9-12–for a complete discussion.*

[1] For purposes of this discussion, IM coverage includes both private IM coverage and IM coverage that is a qualified health plan offered through a government exchange established pursuant to the ACA. IM coverage does NOT include excepted benefit coverage (e.g., accident, vision, dental, and certain specified disease and hospital indemnity plans).

What to Do?

The general information and discussion above is provided to assist employers and their counsel and agents/brokers to analyze compliance issues related to the potential impact of IRS Notice 2013-54 on employer pre-tax funding of individual major medical health coverage and does not constitute legal, financial, or tax advice.

Employers who are considering implementing an arrangement involving pre-tax funding of IM coverage for active employees (through a cafeteria plan or otherwise) should consider the following actions:

- Seek the advice of independent legal counsel to determine the application of IRS Notice 2013-54 to the employer's specific circumstances.

- Request a binding legal opinion from the vendor stating that no adverse tax (including excise tax) or financial consequences will result from adoption of such an arrangement.

- Request that the vendor provide indemnification for any excise taxes imposed as a result of the pre-tax funding of IM coverage.

> **Practice Pointer**: Indemnification that covers only a finding that the arrangement is impermissible is likely insufficient. As noted above and in the ECFC Article, neither payment of IM Coverage premiums through a cafeteria plan nor establishment of an employer payment plan is illegal. However, the failure of the employer payment plan to comply with the ACA's market reform requirements will result in significant excise tax liability (up to $100 per employee per day or $36,500 per employee per year).

EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION

1444 I Street NW, Suite 700 ◆ Washington, DC 20005 ◆ www.ecfc.org ◆ 202-659-4300 *Main* ◆ 202-216-9646 *Fax*

ECFC FLEX REPORTER

Volume 18, Number 2 **June 2014**

Agency Guidance Prohibits Pre-Tax Funding of Individual Medical Coverage For Active Employees

© 2014, John Hickman, Esq. and Ashley Gillihan, Esq., *Alston & Bird, LLP*
(with assistance from William F. Sweetnam Jr., *Groom Law Group*)

The *ECFC FLEX Reporter* provides in-depth coverage of developments affecting the administration of cafeteria plans, flexible spending arrangements (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs). Articles in The ECFC FLEX Reporter are authored by nationally recognized attorneys and consultants, and edited by John R. Hickman, a partner in the Employee Benefits Practice Group of Alston & Bird, LLP.

Agency Guidance Prohibits Pre-Tax Funding of Individual Medical Coverage For Active Employees

© 2014, John Hickman, Esq. and Ashley Gillihan, Esq., *Alston & Bird, LLP*
(with assistance from William F. Sweetnam Jr., *Groom Law Group*)

The *Holy Grail* of defined contribution health arrangements has long been the potential ability to enable employees to fund individual medical premiums on a pre-tax basis. Since 1996, however, the conflict between individual insurer underwriting practices and limitations on employer sponsored health plan discrimination under HIPAA's portability provisions seemed to bar such an innovative approach. But the advent of the Affordable Care Act's ("ACA's") proscription of health based underwriting for insurers seemed to bring a new era for benefit design – or did it?

Late in 2013, the IRS and the Department of Labor ("DOL") issued mirrored guidance that significantly affects the structure of defined contribution arrangements and premium reimbursement arrangements after the enactment of the Affordable Care Act ("ACA") —IRS Notice 2013-54 and Technical Release 2013-03 (collectively, the Agency Guidance). On May 24, 2014, the IRS published two Q&As (the Q&As) that reinforce the position taken in the Agency Guidance regarding contribution arrangements and explain the penalty assessed because the arrangement fails to satisfy the market reform provisions of the ACA. Internal Revenue Service, *Employer Health Care Arrangements*, http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements (last visited June 5, 2014). The Agency Guidance makes arrangements that facilitate the pre-tax payment or reimbursement (and in some cases, even the after-tax payment/reimbursement) of premiums for major medical coverage issued in the individual market (IM Coverage) impermissible. This far-reaching prohibition on pre-tax treatment of IM Coverage is not limited to government exchange coverage; rather, it affects all manifestations of employer subsidized and/or pre-tax funded IM Coverage. The Agency Guidance also makes health reimbursement arrangements (HRAs) and other similar defined contribution arrangements impermissible *unless* they are "integrated" with an employer's group health plan or the reimbursement under such an arrangement is limited to certain excepted benefits.

The Agency Guidance is complex, and much confusion still abounds in the industry regarding the types of arrangements that are affected. Unfortunately, plan sponsors who establish arrangements made impermissible by the Agency Guidance could be subject to substantial excise taxes under Internal Revenue Code Section 4980D so clarity and understanding are paramount. The purpose of this article is to provide stakeholders (brokers, agents, benefit advisors and their client plan sponsors) with the clarity needed to understand and properly apply the Agency Guidance so that excise taxes and other damages are avoided.

Practice Pointer: Throughout this article we refer to the term "IM Coverage". IM Coverage is a reference to policies providing major medical coverage that are issued *in the individual market* including but not limited to policies issued in the government sponsored Exchange. IM Coverage does not include policies that exclusively provide excepted benefits. See Appendix A for a high level summary of the types of coverage that constitute "excepted benefits".

This article asks and answers the following questions:

- Which arrangements are affected by the Agency Guidance?
- Which arrangements affected by the Agency Guidance are permissible and which ones are prohibited?
- What are the consequences of maintaining an impermissible arrangement?
- How did the agencies reach their conclusions?
- When is the Agency Guidance effective?

I. Which arrangements are affected by the Agency Guidance?

The first step in understanding and applying the Agency Guidance is identifying the *types* of arrangements affected by it. We encourage you to abandon, at least for the moment, traditional monikers such as "HRA" or "premium reimbursement arrangements". To fully understand and apply the Agency Guidance, it is imperative that you be able to identify the structures of the affected arrangements, regardless of what they may be called.

The Agency Guidance focuses on two *types* of arrangements:

- ***Any*** employer-based arrangement that facilitates the payment or reimbursement of premiums for IM Coverage. Both pre-tax and after tax arrangements are affected. Also, it doesn't matter whether the arrangement pays or reimburses other expenses (including but not limited to an "HRA"), pays the premiums to the carrier directly or reimburses the individual for premiums paid by that individual.

Practice Pointer: There has been much debate as to whether the Agency Guidance affects cafeteria plans that permit employees to pay their premiums for IM Coverage with pre-tax employee salary reductions. While not specifically mentioned by name, pre-tax salary reduction is clearly within the realm of employer contributions addressed by the Agency Guidance. Moreover, when asked, IRS and Treasury officials have informally indicated that their clear intent was to address such cafeteria plan arrangements.

- Defined contribution reimbursement arrangements, including but not limited to HRAs and Health FSAs. These arrangements typically reimburse all or some Code Section 213(d) expenses. An arrangement that also paid or reimbursed premiums would fit into the first type of arrangements affected by the Agency Guidance as well.

If you (or your client) currently has or is considering ANY arrangement that would fit into either of these two *types* of arrangements, regardless of what they are called or how they are characterized, then the arrangement is affected by the Agency Guidance and you should continue reading.

Which arrangements affected by the Agency Guidance are permissible and which ones are prohibited?

If the arrangement under consideration is one of the types of arrangement affected by the Agency Guidance, then the permissibility of that arrangement will depend, in large part, on the answer to the following:

- Is the arrangement limited to former employees (e.g., retirees) or not? If it is limited to former employees, then it may be permissible under the Agency Guidance;
- Is the arrangement limited to excepted benefits or not? If it is limited to excepted benefits, then the arrangement may be permissible under the Agency Guidance (although other limitations may apply);
- Is the arrangement integrated (as defined by the Agency Guidance) or not? If it is integrated, then it may be permissible.

If not in one of the limited categories above (retiree only, excepted benefit only, or integrated), the affected arrangement is likely not permissible. To help sort through the confusion, we have provided a reference chart below to identify the arrangements that are or are not permissible under the Agency Guidance.

Type of Arrangement	***Permissible or Not Permissible***	***Comments***
Employer-funded, tax free payment or reimbursement of IM coverage (other than an arrangement limited solely to former employees) Such arrangements are commonly referred to as HRAs or Premium Reimbursement Accounts.	Not permissible	Questions still remain whether an arrangement that facilitates the payment or reimbursement of IM Coverage premiums is permissible IF the arrangement is "integrated" with an employer's group health plan, as prescribed by the Agency Guidance. This issue is discussed in more detail below.

Type of Arrangement	*Permissible or Not Permissible*	*Comments*
Payment of IM Coverage premiums by employees with pre-tax salary reductions through an employer's cafeteria plan	Not permissible	Whether cafeteria plans that facilitate the payment or reimbursement of IM Coverage premiums are affected has been a hotly debated issue. However, cafeteria plans are included in the new definition "employer payment plan" (even though not specifically referenced) created by the Agency Guidance, and informal comments from IRS and Treasury officials confirm that interpretation.
Employer-funded after-tax payment or reimbursement that is conditioned on the purchase of IM Coverage (other than through an arrangement limited solely to former employees)	Not permissible	After-tax payments provided by the employer are permissible only to the extent the employee is given the choice to receive the payments in cash OR have them applied to the IM Coverage. And even then, ERISA's voluntary plan safe harbor must be satisfied. See Appendix B for a summary of ERISA's voluntary plan safe harbor.
Employer-funded, after-tax payments that employees can choose to receive in cash or have the employer apply towards the IM Coverage (other than through an arrangement limited solely to former employees)	Permissible if	The arrangement satisfies ERISA's voluntary plan safe harbor. See Appendix B for a summary of ERISA's voluntary plan safe harbor. Note: Great care should be taken with regard to such arrangements since an employer contribution (albeit after-tax) seems, on its face, to potentially violate the ERISA safe harbor. Also, state small group laws would also need to be considered as some states prohibit coverage in which an employer facilitates or reimburses payment.
Employee-funded, voluntary, after-tax payroll deductions for IM Coverage premiums	Permissible if	The arrangement satisfies ERISA's voluntary plan safe harbor. See Appendix B for a summary of ERISA's voluntary plan safe harbor. Note: State small group laws would also need to be considered as some states prohibit coverage in which employer facilitates or reimburses payment.
Employer-funded, direct payment or reimbursement of premiums for policies that provide "excepted benefits". **NOTE: Clarifications made by CMS in the Section 111 reporting manual indicate that direct payment of Medicare Supplemental Policies would be a violation of Medicare's non-discrimination rules for active employees.**	Permissible	Direct payment or reimbursement of premiums of such policies to the carrier should qualify under 106; however, reimbursement of premiums through an HRA for certain excepted benefits might be problematic. See next row in this chart for more details.

Type of Arrangement	*Permissible or Not Permissible*	*Comments*
Reimbursement of premiums for policies that provide the following excepted benefits through an employer-funded HRA: • Dental • Vision	Permissible	In order to qualify for reimbursement through an HRA, coverage must be an otherwise deductible medical expense under Code Section 213. Reimbursement of fixed indemnity policy premiums, even though excepted benefits, would not be permissible since such policies are not considered by the IRS to qualify as "Section 213 medical care".
Stand-alone (i.e. non-integrated), employer-funded defined contribution arrangement that reimburses all 213(d) expenses (other than through an arrangement limited solely to former employees). These are often referred to as HRAs, MERPs or 105 plans.	Not permissible	In order to be permissible, such arrangements would have to be "integrated" as prescribed by the Agency Guidance. See below for a more detailed discussion on the definition of "integrated".
Stand-alone (i.e. non-integrated), employer-funded defined contribution arrangement that reimburses only dental and vision expenses (but NOT preventive care expenses). These are often referred to as limited purpose HRAs.	Likely Permissible	Confirming IRS guidance as to a stand-alone arrangement would be welcome. Many "limited purpose" HRAs reimburse preventive care as well; however, reimbursement of preventive would cause the arrangement to fall outside of the excepted benefit definition.
Health FSA that qualifies as an excepted benefit	Permissible	There still appears to be widespread confusion around when a Health FSA qualifies as an excepted benefit. For example, a Health FSA funded solely with pre-tax salary reductions will not qualify as an excepted benefit if the employer who sponsors the Health FSA does not also offer major medical coverage to employees eligible for the Health FSA. See Appendix A for a more detailed discussion of benefits that qualify as "excepted benefits."
Health FSA that does not qualify as an excepted benefit	Not Permissible unless	The Health FSA is "integrated" with an employer's group health plan, as prescribed by the Agency Guidance.
Health FSA (whether an excepted benefit or not) that reimburses only dental and vision expenses (but NOT preventive care expenses). Such arrangements are often referred to as limited scope Health FSAs.	Likely permissible	Confirming IRS guidance as to a stand-alone arrangement would be welcome. Many "limited purpose" Health FSAs reimburse preventive care as well; however, reimbursement of preventive would cause the arrangement to fall outside of the excepted benefit definition.

Type of Arrangement	*Permissible or Not Permissible*	*Comments*
Employer-funded payments or reimbursements of any 213(d) expense, including premiums for IM Coverage, through arrangement limited to retirees. These are often referred to as Retiree HRAs or Retiree Reimbursement Accounts.	Permissible	The Agency Guidance does not affect arrangements established solely for former employees.

II. What are the consequences of maintaining an impermissible arrangement?

As discussed more fully below, the Agency Guidance applies certain health insurance reforms added by the Affordable Care Act to the Code, ERISA and the Public Health Service Act to the affected arrangements to determine whether such arrangements are permissible. Thus, a plan sponsor that maintains one of the impermissible arrangements identified above would be subject to penalties and taxes arising under the Code and ERISA or the Public Health Service Act (as applicable) for violations of the applicable health insurance reforms. The following is a summary of the penalties and taxes a plan sponsor might incur:

Impermissible arrangements maintained by private employers	
Code Section 4980D	Excise tax equal to $100 per day, per affected beneficiary (cap of $500,000 for non-willful violations)
ERISA	Suits by affected participants and beneficiaries to enforce their rights under ERISA
Impermissible arrangements maintained by non-federal governmental employers	
PHSA	$100 per day penalty, per affected beneficiary Suits by affected participants and beneficiaries to enforce their rights under the PHSA
Impermissible arrangements maintained by church plans	
Code Section 4980D	Excise tax equal to $100 per day, per affected beneficiary. Suits by affected participants and beneficiaries to enforce their rights under the Code

Practice Pointer: The Agency Guidance does not take away the tax favored treatment of pre-tax IM arrangements; rather, impermissible arrangements trigger draconian excise taxes. Consequently, the value of any arrangement that facilitates the payment or reimbursement of IM Coverage premiums is still excluded from income under Code Section 106 and the benefits provided by such arrangement are still tax free under Code Section 105. Unfortunately, the potential excise tax damages resulting from violation of the applicable health insurance reforms likely would far outweigh any tax advantages otherwise provided under Code Section 106 and 105. The IRS released the Q&As in order to clearly state that these arrangements may be subject to the potential excise taxes.

III. The Nitty Gritty: How did the agencies reach their conclusions?

The conclusions reached in the Agency Guidance are a product of two, specific health insurance reforms added by the Affordable Care Act to the PHSA -- PHSA Sections 2711 and 2713. To fully understand how the agencies reached their conclusions in the Agency Guidance (and to properly "kick the tires" of any purported permissible arrangements), we must first understand application of these health insurance reforms.

A. Statutory Background

PHSA Section 2711

Effective with plan years beginning on or after September 23, 2010, all group health plans other than stand-alone retiree health plans and plans for which substantially all of the benefits constitute excepted benefits are prohibited from imposing annual or lifetime dollar limits on essential health benefits.[1] The regulations issued in connection with Section 2711 provide two exceptions to this requirement:

- HRAs that are "integrated" with a group health plan that otherwise complies with Section 2711. "Integrated" is not defined in the regulations.
- A "health flexible spending arrangement" as defined in Code Section 106(c)(2). A Section 106(c)(2) arrangement is ANY medical expense reimbursement arrangement for which the maximum reimbursement does not exceed 500% of the total value of the coverage.

Practice Pointer: The term "health flexible spending arrangement" in Section 106(c)(2) includes *but is not limited to* health FSAs offered through a cafeteria plan.

Thus, in order to conclude that an affected arrangement ***violates*** Section 2711, the following factors have to exist:

- The arrangement must be a group health plan that provides other than excepted benefits or is not offered solely to former employees;
- The arrangement must provide essential health benefits;
- The arrangement must impose an annual dollar limit on essential health benefits; and
- The arrangement must not be otherwise exempt under Section 2711.

PHSA Section 2713

Also effective with plan years beginning on or after September 23, 2010, PHSA section 2713 requires non-grandfathered group health plans, other than stand-alone retiree health plans and plans for which substantially all of the benefits constitute excepted benefits, to cover recommended preventive services and treatments *without cost sharing* (in-network only, if there is a network plan).

Thus, in order to conclude that any affected arrangement ***violates*** Section 2713, the following factors have to exist:

- The arrangement must be a group health plan that provides other than excepted benefits or is not offered solely to former employees, and is not grandfathered; and
- The arrangement must either exclude coverage for recommended preventive care services or limit benefits provided for such coverage.

Practice Pointer: The Agency Guidance also appears to be a product of policy concerns the agencies had related to the following: (i) the impact that arrangements that facilitate the payment/reimbursement of IM Coverage premiums might have on the individual market —especially the Exchange and the subsidies available through the Exchange; and (ii) an employer satisfying its employer responsibility (aka so-called "pay or play") obligations through arrangements that clearly limited the scope of essential health benefits.

B. The Agency Guidance

With respect to PHSA Section 2711, the core of the Departments' analysis relating to IM policies is in Question 1 of the Agency Guidance, which reads as follows:

> **Question 1:** The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply

[1] A comprehensive discussion regarding the definition of "essential health benefits" is beyond the scope of this article.

with the annual dollar limit prohibition. May other types of group health plans used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the annual dollar limit prohibition?

Answer 1: No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the annual dollar limit prohibition.

For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However the employer payment plan will fail to comply with the annual dollar limit prohibition because (1) an employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

With respect to the preventive care requirements of PHSA Section 2713, the core of the Departments' analysis relating to IM policies is in Question 3 of the Agency Guidance. Question 3 is essentially the same as Question 1, and reads as follows:

Question 3: The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply with the annual dollar limit prohibition. May a group health plan, including an HRA, used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the preventive services requirements?

Answer 3: No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the preventive services requirements.

For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However, the employer payment plan will fail to comply with the preventive services requirements because (1) an employer payment plan does not provide preventive services without cost-sharing in all instances, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

In contrast to Questions 1 and 3 with respect to arrangements used to purchase IM coverage, the Agency Guidance provides that an "HRA" that is integrated with a group health plan complies with PHSA Section 2711 and PHSA Section 2713 if the underlying group health plan complies with these requirements. The Agency Guidance also provides detailed rules on how HRAs may be integrated with group health plans that satisfy such requirements. See Questions 2, 4-6 of the Agency Guidance.

Practice Pointer: Did the agencies intend to limit the special integration rules to "HRAs" or does it apply to any employer-funded defined contribution reimbursement arrangement? "HRA" has become the common term for any employer-funded, defined contribution reimbursement account; however, HRAs are, by technical definition, limited to employer-funded, defined contribution reimbursement arrangements that have a carryover feature, as defined in IRS Notice 2002-45. In addition, the exception in the Section 2711 regulations is limited to "HRAs" that are integrated with a compliant group health plan. Nevertheless, we believe the agencies intended to refer to the broader, more common application of "HRA" for three reasons. First, the Agency Guidance implies that the integration exception in Section 2711 is available to defined contribution arrangements other than HRAs simply by the permissibility of integration with IM Coverage. If the integration exception was limited to "HRAs" as defined in Notice 2002-45, employer payment plans and other group health plans that are not HRAs would categorically fail Section 2711 – not because they cannot be integrated with the IM Coverage, but because they are not HRAs. Second, the agencies subsequently, and very quietly, issued an FAQ that applies the integration rules from the Agency Guidance to "Health FSAs" that are not excepted benefits. This suggests that they did not intend to limit the integration concept only to the Notice 2002-45 HRAs. Third, applying the integration rules ONLY to HRAs as defined in Notice 2002-45 would have illogical results not warranted by the differences in an "HRA" defined in Notice 2002-45 and any other employer-funded, defined contribution reimbursement arrangement that does not have a carryover. For example, Section 2711 only provides an exemption for plans that do not

otherwise provide excepted benefits to the extent that they are (i) "HRAs" integrated with group health plans that satisfy the 2711 requirements; or (ii) "Health FSAs" as defined in Code Section 106(c), which the Agency Guidance further limits to Health FSAs offered through a cafeteria plan. If you adopt the interpretation that the "HRA" referred to in this scenario means only the Notice 2002-45 variety (i.e. an account with a carryover), then NO employer funded, defined contribution reimbursement arrangement without a carryover could exist, even if it otherwise satisfied the 2013-54 integration requirements, *simply because it did not have a carryover feature.*[2]

The Agency Guidance introduces the term "employer payment plan," which has not been previously defined. "Employer payment plans" are referred to in Section I of the Agency Guidance, which provides that, among other things, the Guidance addresses the application of the ACA to "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, such as a reimbursement arrangement described in Revenue Ruling 61-146, 1961-2 CB 25, or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee (collectively, an employer payment plan)."

Employer payment plans are also described in Section II.B., of the Agency Guidance, as follows:

> **B**. **Employer Payment Plans**
> Revenue Ruling 61-146 holds that if an employer reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance, the payments are excluded from the employee's gross income under Code § 106. This exclusion also applies if the employer pays the premiums directly to the insurance company. An employer payment plan, as the term is used in this notice, does not include an employer-sponsored arrangement under which an employee may choose either cash or an after-tax amount to be applied toward health coverage. Individual employers may establish payroll practices of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee without establishing a group health plan, if the standards of the DOL's regulation at 29 C.F.R. §2510.3-1(j) [relating to voluntary plans] are met.

The Agencies' use of the ERISA safe harbor to define the scope of permitted after-tax arrangements is significant in that any employer involvement (beyond merely allowing payroll deduction) can trigger employer payment plan status – thereby making the arrangement impermissible. This prohibition goes well beyond prohibiting employer contributions, and likely requires that employers take great care to ensure that they are not perceived as the promoter or sponsor of such arrangements. See Appendix B for a brief high level discussion of the ERISA safe harbor.

IV. Applying the Agency Guidance to affected arrangements

The Agency Guidance indicates that affected arrangements that are identified above as impermissible violate Sections 2711 and 2713. The following summarizes how they applied those health insurance reforms to each of the 2 types of affected arrangement to reach those conclusions.

A. Arrangements that facilitate the payment or reimbursement of IM Coverage Premiums

- As a threshold matter, Sections 2711 and 2713 will apply only to the extent that the arrangement is a group health plan. There is no question that arrangements that reimburse some or all Code Section 213(d) expenses, including but not limited to IM Coverage premiums, qualify as group health plans. But what about arrangements that ONLY facilitate the payment or reimbursement of IM Coverage premiums? The Agency Guidance ensures that such arrangements are also treated as a "group health plan" by creating the "employer payment plan." As noted above, an employer payment plan is *any* arrangement for which the cost of such coverage is excluded from income under Code Section 106, as prescribed in Rev. Ruling 61-146. This would also include cafeteria plans that facilitate the payment of IM Coverage premiums. Although not specifically referenced in the definition of employer payment plan, the definition of employer payment plans would necessarily include cafeteria plans that allow employees to

[2] Also, plans are permitted to use "HRAs" to satisfy minimum value to the extent reimbursement is limited to expenses otherwise covered by the plan. Since the minimum value rules refer solely to an "HRA", does this mean that health plans may NOT use a defined contribution reimbursement arrangement to satisfy minimum value if it doesn't also have a carryover feature? As with the Agency Guidance, we believe the reference to "HRA" is a reference to the broader term used to define any employer-funded defined contribution reimbursement arrangement.

pay IM Coverage with pre-tax salary reductions.[3] IRS and Treasury officials have informally confirmed that employer payment plans include such cafeteria plans.

Practice Pointer: Revenue Ruling 61-146 indicates that payments or reimbursements for IM Coverage premiums are excluded from income under 106. Does this somehow open the door to an argument that a *reimbursement* for premiums that is exempt under Code Section 105 avoids the reach of the Agency Guidance? NO!!!!! Prior to the agency guidance, we might have argued that the arrangement that paid or reimbursed the premiums was not a group health plan in and of itself in light of 61-146. In fact, the premium payment/reimbursement would have simply been considered an employer contribution to the group health plan for which the benefits were provided by the policy. However, the guidance merely uses Rev. Ruling 61-146 to help define an employer payment plan, which for purposes of the Agency Guidance constitutes a group health plan that provides a premium reimbursement that is excluded from income under Code Section 105. Thus, any argument that "105 arrangements" survive the Agency Guidance because they are not employer payment plans falls very short.

Also, arrangements that facilitate the payment or reimbursement of IM Coverage premiums with after-tax dollars will also constitute an employer payment plan unless (i) employees have a choice whether to receive the after-tax payments in cash or have them applied to the IM Coverage premiums and (ii) the arrangement does not violate ERISA's voluntary plan safe harbor. See Appendix B for a more detailed overview of ERISA's voluntary plan safe harbor.

- All group health plans are subject to Section 2711 unless they qualify as excepted benefit plans or they do not provide essential health benefits. Premiums do not appear in the list of essential health benefit categories; however, since the Agency Guidance categorically concludes that such arrangements violate Section 2711 (as do the later-issued Q&As), the agencies are *necessarily* concluding that premium payments or reimbursement constitute essential health benefits.[4] In addition, an arrangement that facilitates the payment of IM Coverage premium would not fit into any of the excepted benefit categories (see Appendix A for a summary of the excepted benefit plans).

Practice Pointer: If premiums are not in the list of essential health benefits, how does a premium payment or reimbursement constitute an essential health benefit? In essence, the agencies look through the reimbursement to the IM Coverage and treat the payment/reimbursement by an arrangement as an essential health benefit if the policy for which the premiums are paid or reimbursed by the arrangement also provides essential health benefits. Since all IM Coverage provides essential health benefits, then the payment or reimbursement of the premiums for IM Coverage constitutes an essential health benefit.

- Even though the payment or reimbursement of IM Coverage constitutes an essential health benefit, Section 2711 is not violated if there is no annual dollar limit imposed on the essential health benefit. For example, one argument might be that an employer avoids this problem by agreeing to pay for all IM Coverage premium expenses without limitation. Unfortunately, the Agency Guidance is very clear that an arrangement that pays or reimburses IM Coverage *necessarily* imposes an annual dollar limit on the benefit up to the amount of the premiums on the IM Coverage purchased through the arrangement.[5]

[3] According to pre-ACA proposed IRS regulations under Code Section 125 and Rev. Rul. 61-146, employers are permitted under Code Section 125 to allow employees to pay for IM Coverage (other than through the Exchange) premiums (as well as other accident and health insurance plans issued in the individual market) with pre-tax salary reductions provided that (i) the policies are included in the cafeteria plan (e.g. by general description) and (ii) payment is made through one of the 3 permissible methods outlined in 61-146. To the extent this pre-ACA guidance would seem to allow pre-tax IM Coverage, it would be superseded by the more recent Agency Guidance.

[4] However the absence of a clear statement to this effect has enabled the promoters of these arrangements to argue that the premiums are not essential health benefits. See Robb Mandelbaum, *Risking a Health Insurance Strategy the I.R.S. May Not Approve*, N.Y. Times, June 5, 2014.

[5] See Q-1. When explaining why the employer payment plan in the example violates Section 2711, Q-1 states: "An employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement. . . ." Note, however, that the conclusion reached would not be limited to employer payment plans. It would necessarily extend to any arrangement that paid or reimbursed IM Coverage premiums.

- Since such arrangements impose an annual dollar limit on essential health benefits, Section 2711 is violated unless one of the other exceptions to Section 2711 applies. First, and perhaps most importantly, Section 2711 indicates that "HRAs" are exempt from the prohibitions in Section 2711 they are integrated with a group health plan that complies with Section 2711. Although IM Coverage paid for by the employer could qualify as a "group health plan," the Agency Guidance quickly closes this potential door by indicating that the arrangement cannot be integrated with the IM Coverage.

Practice Pointer: Could an arrangement that facilitates the payment or reimbursement of IM Coverage premiums avoid violations of 2711 if it was "integrated" with an employer's group health plan, as prescribed by the Agency Guidance? Maybe. While it doesn't appear to be intended by the agencies, the Agency Guidance seems to leave the door open to an arrangement that facilitates the payment or reimbursement of IM Coverage premiums **to the extent that the arrangement is integrated with an employer's group health plan that provides minimum value** (without regard to the coverage provided by the arrangement).[6] See below for a more detailed discussion of the integration rules. In addition, whether an arrangement that reimburses premiums could escape the reach of Section 2711 depends on whether the agencies intended to limit the integration exception to "HRAs". Although the Section 2711 regulations and the Agency Guidance apply the integration exception to HRAs, we do not think it is limited to HRAs, as discussed above.

- Also, the Section 2711 regulations indicate that an arrangement that is a "health flexible spending arrangement" as defined by Code Section 106(c)(2) is exempt from Section 2711. A health flexible spending arrangement is defined by Code Section 106(c)(2) as any arrangement for which the maximum reimbursement is less than 500% of the total value of the coverage. Such arrangements would include, but not be limited to, Health FSAs offered through a cafeteria plan. Thus, it would appear from the regulations that any defined contribution arrangement that satisfied the definition of health flexible spending arrangement could survive the Agency Guidance. Unfortunately the Agency Guidance indicates that it is their intent, and future regulations will express this, that the health flexible spending arrangement exception in Section 2711 is limited to Health FSAs offered through a cafeteria plan. This is bad news because Health FSAs offered through a cafeteria plan are prohibited under the Code Section 125 regulations from paying or reimbursing premiums for health coverage.

Practice Pointer: Does the Agency Guidance's application of Section 2711 apply only to employer payment plans? NO. The guidance is very clear that it applies to all group health plans that are used to purchase IM coverage, which includes but is not limited to HRAs and employer payment plans.

- Likewise, an arrangement that facilitates the payment or reimbursement of IM Coverage premiums would violate Section 2713 as well unless it was integrated with an employer's group health plan that provides minimum value (MV) coverage on its own, as prescribed by the Agency Guidance.[7]

B. Defined contribution reimbursement arrangements, including but not limited to HRAs and Health FSAs

- Defined contribution reimbursement arrangements will also violate Section 2711 unless:
  - The arrangement is integrated with an employer's group health plan, as prescribed by the Agency Guidance;
  - The arrangement qualifies as an excepted benefit; or
  - The arrangement is a Health FSA offered through a cafeteria plan that meets the requirements of Code Section 106(c)(2).

Practice Pointer: The Agency Guidance appears to refer only to HRAs in this context. As discussed above, we do not believe that the agencies intended to refer solely to HRAs defined in Notice 2002-45 (i.e. employer-funded, defined contribution arrangements that have a carryover). Instead, we believe that the Agency Guidance refers to ANY defined

[6] Also, the minimum value rules indicate that a group health plan can consider the benefits provided by an HRA when doing the minimum value determination only to the extent the HRA's reimbursement is limited to expenses covered by the group health but for a financial limitation.

[7] Certain grandfathered plans may avoid the Section 2713 preventive care mandate; but they would be prohibited under the Section 2711 annual cap prohibition *unless* they satisfy the integration with MV coverage requirement.

contribution arrangement for the reasons we identify above.

- An arrangement is "integrated" in accordance with the Agency Guidance if the following requirements are satisfied:
  - Participation in the defined contribution reimbursement arrangement is limited to those employees who also participate in an employer's traditional major medical (i.e. so-called defined benefit) group health plan. The traditional group health plan must itself satisfy all of the ACA requirements.

Practice Pointer: The Agency Guidance clarifies that participation in a defined contribution reimbursement arrangement does not have to be limited to a traditional (i.e., defined benefit) health plan of the same employer—it can be integrated with a plan of another employer (e.g. the spouse's employer). In that case, the employer would simply seek certification that the employee or spouse was covered under another defined benefit group health plan.

  - Employees and dependents must be offered the opportunity to opt out and also permanently waive future reimbursements after coverage under the employer's defined benefit group health plan ceases (e.g. if there is a spend down provision).

Practice Pointer: A defined contribution reimbursement arrangement that is integrated with an employer's group health plan that is voluntary would presumably satisfy the opt-out requirement by virtue of the individual's choice to enroll (or not) in the employer's plan. Moreover, if the defined contribution does not automatically offer a spend-down opportunity for unused funds, then the requirement to allow employees and dependents to waive future reimbursements would not appear to apply in practice.

  - If the scope of reimbursement under the defined contribution arrangement exceeds the following expenses, then the employer's group health plan must also provide minimum value:
    - Copayments under the employer's group health plan
    - Co-insurance under the employer's group health plan
    - Deductibles under the employer's group health plan
    - Premiums under the employer's group health plan [NOTE: don't forget that Notice 2002-45 prohibits an HRA with a carry-over from paying premiums if the employee can also pay the premiums with pre-tax salary reductions]
    - Non-essential health benefits

Practice Pointer: As discussed above, it appears at first glance that defined contribution arrangement could pay or reimburse IM Coverage premiums so long as it is "integrated" with an employer's ACA compliant group health plan that also provides minimum value. However, it is our understanding from IRS and Treasury officials that this may be an unintended result.

  In addition, the Agency Guidance clarifies that a defined contribution reimbursement arrangement that is otherwise integrated with an employer group health plan is still considered "integrated" for purposes of these rules if participants who cease to be covered under the employer group health plan are permitted to use any unused amounts allocated to the HRA *while the HRA was integrated*.

- A defined contribution arrangement that qualifies as an excepted benefit will also not violate Section 2711. Thus, it would appear that a defined contribution reimbursement arrangement that limits its reimbursement to dental or vision expenses and/or premiums for most excepted benefit coverages would constitute an excepted benefit plan.

- If the arrangement qualifies as a health flexible spending arrangement, as defined in code Section 106(c)(2), then it is exempt from Section 2711. As noted above, the agencies intend for this special exemption in Section 2711 to apply only to Health FSAs offered through a cafeteria plan.

- If the defined contribution arrangement is not an excepted benefit plan, then it will also violate Section 2713 unless it is integrated with the employer's group health plan as prescribed in the Agency Guidance.

When is the Agency Guidance effective?

The Agency Guidance is generally effective for plan years beginning on or after January 1, 2014, which generally means that current arrangements with plan years beginning after this date in 2014 that are deemed impermissible by the Agency Guidance will need to wind down before the first day of the plan year that begins in 2014. Arrangements with plan years that have already started in 2014 should have already wound down. Nevertheless, it would appear, even though not specifically stated in the Agency Guidance, that unused amounts from the 2013 plan year may be spent down without violating Sections 2711 and 2713. The FAQ issued in January 2013 – prior to the Agency Guidance – indicated that the agencies expected future guidance to allow participants in stand-alone HRAs to continue using amounts not used by December 31, 2013 up to maximum permitted by the HRA or, if the plan did not specifically identify a maximum carry over, up to an amount equal to the contributions allocated to the HRA in 2012. IRS and Treasury officials have informally indicated that plan sponsors may rely on the FAQ.

In Conclusion

A careful reading of the Agency Guidance makes it abundantly clear that arrangements that facilitate the pre-tax payment or reimbursement (and in some cases, even the after-tax payment/reimbursement) of premiums for IM coverage for active employees are impermissible. This far-reaching prohibition on pre-tax treatment of IM Coverage is not limited to government exchange coverage; rather, it affects all manifestations of employer subsidized and/or pre-tax funded IM Coverage. The Agency Guidance also makes health reimbursement arrangements (HRAs) and other similar defined contribution arrangements for active employees impermissible *unless* they are "integrated" with an employer's group health plan or the reimbursement under such an arrangement is limited to retiree only arrangements or certain excepted benefits.

Appendix A
High-Level Recap of Excepted Benefits Under ACA and HIPAA

- Benefits that are excluded under all circumstances:
  - Accident or disability income insurance;
  - Liability insurance, including general liability and auto liability insurance;
  - Workers' compensation;
  - Automobile medical payment insurance;
  - Credit only insurance;
  - Coverage for on-site medical clinics.

- The following benefits are exempt when offered through a separate policy or, alternatively, if they do not otherwise constitute an integral part of the plan. For this purpose a benefit is not an integral part of the plan if the participant has the right to elect the coverage separately from medical and, if the participant elects to receive the coverage, the participant is charged a separate premium or contribution.
  - "Limited scope" dental or vision benefits. "Limited scope dental coverage" is defined as coverage substantially all of which consists of treatment of the mouth. Likewise, limited scope vision coverage is defined as coverage substantially all of which is treatment for the eyes.
  - Long-term care
  - Nursing home care
  - Home health care
  - Community-based care

- Limited scope specified disease and hospital (or other fixed) indemnity coverage is exempt from HIPAA provided that:
  - Such coverage is provided under a separate policy, certificate or contract of insurance;
  - No coordination exists between the provision of such benefits and any exclusion under any plan maintained by that employer;
  - Benefits are paid for an event regardless of whether benefits are provided under any group health plan maintained by the same plan sponsor.

- The following types of benefits if offered under a separate policy or contract:
  - Medicare supplemental policy;
  - TRICARE supplemental policy;
  - Coverage providing "similar" supplemental coverage to a group health plan.[8]

- Health FSA (as defined in Code Section 106(c)(2) that satisfies the following requirements)
  - Other major medical coverage is offered by the same employer to the group of employees eligible for the Health FSA (unlike the 2013-54 integration rules, the employee or dependent does not have to be enrolled in the major medical plan for the FSA to qualify as an excepted benefit—the other coverage merely needs to be made available)
  - The maximum reimbursement does not exceed two (2) times the employee's salary reduction or, if greater, the employee's salary reduction plus $500.

[8] The final regulations clarify that the exception for "similar supplemental coverage" is limited to coverage that is specifically designed to fill gaps in the primary health coverage such as coinsurance or deductibles (e.g., such as a Medi-Gap or CHAMPUS/TRICARE supplement plan). Coverage that is supplemental only because of the plan's coordination provisions is not "similar supplemental coverage."

Appendix B
ERISA Voluntary Plan Safe Harbor

Regulations issued by the Department of Labor ("DOL") under ERISA exclude from ERISA applicability certain voluntary group *or group type* arrangements to the extent all four of the following conditions are satisfied:

(i) no contributions are made by the employer;
(ii) participation in the program is completely voluntary;
(iii) the sole function of the employer is, *without endorsing the program*, to merely permit the insurer to publicize the program and collect premiums through payroll deductions; and
(iv) the employer receives no consideration other than reimbursement of reasonable expenses incurred in connection with the program.[1]

In many cases, satisfaction of the voluntary plan safe harbor will hinge on whether the employer "endorses" the program or encourages employees to participate. There is a fairly robust body of case law that identifies factors of endorsement. Factors cited by courts include, but are not limited to: offering coverage pre-tax; paying some or all of the cost of coverage; selecting the insurer; calling the coverage a "benefit," including the coverage in an SPD; obtaining a "list billed" discount for employees.

[1] See 29 C.F.R. 2510.3-1(j)

Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements

Notice 2013-54

I. PURPOSE AND OVERVIEW

This notice provides guidance on the application of certain provisions of the Affordable Care Act[1] to the following types of arrangements: (1) health reimbursement arrangements (HRAs), including HRAs integrated with a group health plan; (2) 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, such as a reimbursement arrangement described in Revenue Ruling 61-146, 1961-2 CB 25, or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee (collectively, an employer payment plan); and (3) certain health flexible spending arrangements (health FSAs). This notice also provides guidance on section 125(f)(3) of the Internal Revenue Code (Code) and on employee assistance programs or EAPs.

The Departments of the Treasury (Treasury Department), Health and Human Services (HHS), and Labor (DOL) (collectively, the Departments) are continuing to work together to develop coordinated regulations and other administrative guidance to assist stakeholders with implementation of the Affordable Care Act. The guidance in this notice is being issued in substantially identical form by DOL, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this notice.

II. BACKGROUND

A. Health Reimbursement Arrangements

An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Code § 213(d)) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. IRS Notice 2002-45, 2002-02 CB 93; Revenue Ruling 2002-41, 2002-2 CB 75. This reimbursement is excludable from the employee's income. Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years. HRAs generally are considered to be group health plans within the meaning of Code § 9832(a), § 733(a) of the Employee Retirement Income Security Act of 1974 (ERISA), and § 2791(a) of the Public Health Service Act (PHS Act) and are subject to the rules applicable to group health plans.

[1] The "Affordable Care Act" refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148) (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10).

B. Employer Payment Plans

Revenue Ruling 61-146 holds that if an employer reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance, the payments are excluded from the employee's gross income under Code § 106. This exclusion also applies if the employer pays the premiums directly to the insurance company. An employer payment plan, as the term is used in this notice, does not include an employer-sponsored arrangement under which an employee may choose either cash or an after-tax amount to be applied toward health coverage. Individual employers may establish payroll practices of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee without establishing a group health plan, if the standards of the DOL's regulation at 29 C.F.R. §2510.3-1(j) are met.

C. Health Flexible Spending Arrangements (Health FSAs)

In general, a health FSA is a benefit designed to reimburse employees for medical care expenses (as defined in Code § 213(d), other than premiums) incurred by the employee, or the employee's spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.125-5); Code §§ 105(b) and 106(f). Contributions to a health FSA offered through a cafeteria plan satisfying the requirements of Code § 125 (a Code § 125 plan) do not result in gross income to the employee. Code § 125(a). While employees electing coverage under a health FSA typically also elect to enter into a salary reduction agreement, employers may provide additional health FSA benefits in excess of the salary reduction amount. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43955-43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §§1.125-1(r), 1.125-5(b)). For plan years beginning after December 31, 2012, the amount of the salary reduction is limited by Code § 125(i) to $2,500 (indexed annually for plan years beginning after December 31, 2013). See IRS Notice 2012-40, 2012-26 IRB 1046, for more information about the application of the limitation. Additional employer contributions are not limited by Code § 125(i).

The Code, ERISA, and the PHS Act impose various requirements on group health plans, but certain of these requirements do not apply to a group health plan in relation to its provision of excepted benefits. Code § 9831(b), ERISA § 732(b), PHS Act §§ 2722(b) and 2763. Although a health FSA is a group health plan within the meaning of Code § 9832(a), ERISA § 733(a), and PHS Act § 2791(a), a health FSA may be 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, 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). 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. §146.145(c)(3)(v).

D. Affordable Care Act Guidance

1. Market Reforms — In General

The Affordable Care Act contains certain market reforms that apply to group health plans (the market reforms).[2] In accordance with Code § 9831(a)(2) and ERISA § 732(a), the market reforms do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year, and, in accordance with Code § 9831(b), ERISA § 732(b), and PHS Act §§ 2722(b) and 2763, the market reforms also do not apply to a group health plan in relation to its provision of excepted benefits described in Code § 9832(c), ERISA § 733(c) and PHS Act § 2791(c).[3] Excepted benefits include, among other things, accident-only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and certain health FSAs.

The market reforms specifically addressed in this notice are:[4]

(a) PHS Act § 2711 which provides that a group health plan (or a health insurance issuer offering group health insurance coverage) may not establish any annual limit on the dollar amount of benefits for any individual—this rule does not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing an annual limit, with respect to any individual, on specific covered benefits that are not essential health benefits[5] to the extent that such limits are otherwise permitted under applicable law (the annual dollar limit prohibition); and

(b) PHS Act § 2713 which requires non-grandfathered group health plans (or health insurance issuers offering group health insurance plans) to provide certain preventive services without imposing any cost-sharing requirements for these services (the preventive services requirements).

---

[2] Section 1001 of the ACA added new PHS Act §§ 2711-2719. Section 1563 of the ACA (as amended by ACA § 10107(b)) added Code § 9815(a) and ERISA § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

[3] See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010). See also Affordable Care Act Implementation FAQs Part III, Question 1, available at http://www.dol.gov/ebsa/faqs/faq-aca3.html and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html.

[4] The Departments previously addressed HRAs and the requirements under PHS Act § 2715 (summary of benefits and coverage and uniform glossary). See 77 Fed. Reg. 8668, 8670-8671 (February 14, 2012); see also Affordable Care Act Implementation FAQs Part VIII, Question 6, available at http://www.dol.gov/ebsa/faqs/faq-aca8.html and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html and see page 1 of the Instruction Guide for Group Coverage, available at http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf.

[5] See ACA § 1302(b) for the definition of “essential health benefits”.

2. Prior Guidance on the Application of the Market Reforms to HRAs

The preamble to the interim final regulations implementing the annual dollar limit prohibition states that if an HRA is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual dollar limit prohibition, the fact that benefits under the HRA by itself are limited does not fail to comply with the annual dollar limit prohibition because the combined benefit satisfies the requirements. Further, the preamble states that in the case of a standalone HRA that is limited to retirees, the exemption from the requirements of the Code and ERISA relating to the Affordable Care Act for plans with fewer than two current employees means that the retiree-only HRA is not subject to the annual dollar limit prohibition. 75 Fed. Reg. 37188, 37190-37191 (June 28, 2010).

On January 24, 2013, the Departments issued FAQs that address the application of the annual dollar limit prohibition to certain HRA arrangements (HRA FAQs).[6] In the HRA FAQs, the Departments state that an HRA is not integrated with primary health coverage offered by an employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage that is provided by the employer and that meets the annual dollar limit prohibition. Further, the HRA FAQs indicate that the Departments intend to issue guidance providing that:

(a) for purposes of the annual dollar limit prohibition, an employer-sponsored HRA cannot be integrated with individual market coverage or with individual policies provided under an employer payment plan, and, therefore, an HRA used to purchase coverage on the individual market under these arrangements will fail to comply with the annual dollar limit prohibition; and

(b) an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in the coverage, and any HRA that credits additional amounts to an individual, when the individual is not enrolled in primary coverage meeting the annual dollar limit prohibition provided by the employer, will fail to comply with the annual dollar limit prohibition.

The HRA FAQs also state that the Departments anticipate that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, may 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 annual dollar limit prohibition. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing

---

[6] See Affordable Care Act Implementation FAQs Part XI, available at http://www.dol.gov/ebsa/faqs/faq-aca11.html and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html.

for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

3. Prior Guidance on the Application of the Market Reforms to Health FSAs

Under the interim final rules implementing the annual dollar limit prohibition, a health FSA, as defined in Code § 106(c)(2), is not subject to the annual dollar limit prohibition. See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this notice limiting the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

4. Prior Guidance on the Application of Code §§ 36B and 5000A

Section 36B of the Code allows a premium tax credit to certain taxpayers who enroll (or whose family members enroll) in a qualified health plan (QHP) through an Affordable Insurance Exchange (referred to in this notice as an Exchange, and also referred to in other published guidance as a Marketplace). The credit subsidizes a portion of the premiums for the QHP. In general, the premium tax credit may not subsidize coverage for an individual who is eligible for other minimum essential coverage. If the minimum essential coverage is eligible employer-sponsored coverage, however, an individual is treated as eligible for that coverage only if the coverage is affordable and provides minimum value or if the individual enrolls in the coverage.

Coverage provided through Code § 125 plans, employer payment plans, health FSAs, and HRAs are eligible employer-sponsored plans and, therefore, are minimum essential coverage, unless the coverage consists solely of excepted benefits. See Code § 5000A(f)(2) and Treas. Reg. §1.5000A-2, 78 Fed. Reg. 53646, 53658 (August 30, 2013).

Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan and that an employee may use to pay premiums are counted for purposes of determining affordability of an eligible employer-sponsored plan under Code § 36B. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)). Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan are counted toward the plan's minimum value percentage for that plan year if the amounts may be used only to reduce cost-sharing for covered medical expenses and the amount counted for this purpose is the amount of expected spending for health care costs in a benefit year. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). See Q&A 11 of this notice for more explanation of the application of these rules to HRAs and other arrangements.

III. GUIDANCE

A. Guidance on HRAs and Certain other Employer Healthcare Arrangements, Health FSAs, and Employee Assistance Programs or EAPs Under the Joint Jurisdiction of the Departments

1. Application of the Market Reform Provisions to HRAs and Certain other Employer Healthcare Arrangements

Question 1: The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply with the annual dollar limit prohibition. May other types of group health plans used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the annual dollar limit prohibition?

Answer 1: No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the annual dollar limit prohibition.

For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However the employer payment plan will fail to comply with the annual dollar limit prohibition because (1) an employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

Question 2: How do the preventive services requirements apply to an HRA that is integrated with a group health plan?

Answer 2: Similar to the analysis of the annual dollar limit prohibition, an HRA that is integrated with a group health plan will comply with the preventive services requirements if the group health plan with which the HRA is integrated complies with the preventive services requirements.

Question 3: The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply with the annual dollar limit prohibition. May a group health plan, including an HRA, used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the preventive services requirements?

Answer 3: No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the preventive services requirements.

For example, a group health plan, such as an employer payment plan, that reimburses

employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However, the employer payment plan will fail to comply with the preventive services requirements because (1) an employer payment plan does not provide preventive services without cost-sharing in all instances, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

Question 4: Under what circumstances will an HRA be integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements?

Answer 4: An HRA will be integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if it meets the requirements under either of the integration methods described below. Pursuant to this notice, under both methods, integration does 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, if applicable.

Integration Method: Minimum Value Not Required

An HRA is integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if (1) the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits; (2) 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 employer sponsors the plan (non-HRA group coverage); (3) the HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse); (4) 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, as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits; and (5) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of 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 permanently opt out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage under Code § 5000A (see Q&A 10 of this notice) and will therefore preclude the individual from claiming a Code § 36B premium tax credit.

Integration Method: Minimum Value Required

Alternatively, an HRA that is not limited with respect to reimbursements as required under the integration method expressed above is integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services

requirements if (1) the employer offers a group health plan to the employee that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii); (2) the employee receiving the HRA is actually enrolled in a group health plan that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii), regardless of whether the employer sponsors the plan (non-HRA MV group coverage); (3) the HRA is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the employer sponsors the non-HRA MV group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a plan maintained by an employer of the employee's spouse); and (4) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of 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 permanently opt out of and waive future reimbursements from the HRA.

Example (Integration Method: Minimum Value Not Required)

Facts. Employer A sponsors a group health plan and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA group coverage through a family member. Employer A's HRA is limited to reimbursement of co-payments, co-insurance, deductibles, and premiums under Employer A's group health plan or other non-HRA group coverage (as applicable), as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA group coverage. When seeking reimbursement under Employer A's HRA, Employee X attests that the expense for which he seeks reimbursement is a co-payment, co-insurance, deductible, or premium under Employer B's non-HRA group coverage or medical care (as defined under Code § 213(d)) that is not an essential health benefit.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

Example (Integration Method: Minimum Value Required)

Facts. Employer A sponsors a group health plan that provides minimum value and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA MV group coverage through a family member. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon

termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA MV group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA MV group coverage and that the coverage provides minimum value.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA MV group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

Question 5: May an employee who is covered by both an HRA and a group health plan with which the HRA is integrated, and who then ceases to be covered under the group health plan that is integrated with the HRA, be permitted to use the amounts remaining in the HRA?

Answer 5: Whether or not an HRA is integrated with other group health plan coverage, 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 ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms. Note that coverage provided through an HRA, other than coverage consisting solely of excepted benefits, is an eligible employer-sponsored plan and, therefore, minimum essential coverage under Code § 5000A.

Question 6: Does an HRA impose an annual limit in violation of the annual dollar limit prohibition if the group health plan with which an HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits (but limits the coverage to the HRA's maximum benefit)?

Answer 6: In general, an HRA integrated with a group health plan imposes an annual limit in violation of the annual dollar limit prohibition if the group health plan with which the HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit. This situation should not arise for a group health plan funded through non-grandfathered health insurance coverage in the small group market, as small group market plans must cover all categories of essential health benefits, with the exception of pediatric dental benefits, if pediatric dental benefits are available through a stand-alone dental plan offered in accordance with 45 C.F.R. §155.1065.[7]

[7] Small group market plans will not be considered to fail to meet qualified health plan certification standards based solely on the fact that they exclude coverage of pediatric dental benefits that are otherwise required under ACA § 1302(b)(1)(J) where a stand-alone dental plan is also available. See

However, under the integration method available for plans that provide minimum value described under Q&A 4 of this notice, if a group health plan provides minimum value under Code § 36B(c)(2)(C)(ii), an HRA integrated with that group health plan will not be treated as imposing an annual limit in violation of the annual dollar limit prohibition, even if that group health plan does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit.

2. Application of the Market Reforms to Certain Health FSAs

Question 7: How do the market reforms apply to a health FSA that does not qualify as excepted benefits?

Answer 7: The market reforms do not apply to a group health plan in relation to its provision of benefits that are excepted benefits. Health FSAs are group health plans but will be considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).[8] See 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. § 146.145(c)(3)(v). Therefore, a health FSA that is considered to provide only excepted benefits is not subject to the market reforms.

If an employer provides a health FSA that does not qualify as excepted benefits, the health FSA generally is subject to the market reforms, including the preventive services requirements. Because a health FSA that is not excepted benefits is not integrated with a group health plan, it will fail to meet the preventive services requirements.[9]

The Departments understand that questions have arisen as to whether HRAs that are not integrated with a group health plan may be treated as a health FSA as defined in Code § 106(c)(2). Notice 2002-45, 2002-02 CB 93, states that, assuming that the maximum amount of reimbursement which is reasonably available to a participant under an HRA is not substantially in excess of the value of coverage under the HRA, an HRA is a health FSA as defined in Code § 106(c)(2). This statement was intended to clarify the rules limiting the payment of long-term care expenses by health FSAs. The Departments are also considering whether an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition. In any event, the

---

ACA § 1302(b)(4)(F) and Question 5, CMS QHP Dental Frequently Asked Questions, May 31, 2013, https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf.

[8] An HRA is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a Code § 125 plan. IRS Notice 2002-45, 2002-02 CB 93.

[9] Under the interim final rules implementing the annual dollar limit prohibition, a health FSA is not subject to the annual dollar limit prohibition, regardless of whether the health FSA is considered to provide only excepted benefits. See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this notice regarding the restriction of the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

treatment of an HRA as a health FSA that is not excepted benefits would not exempt the HRA from compliance with the other market reforms, including the preventive services requirements, which the HRA would fail to meet because the HRA would not be integrated with a group health plan. This analysis applies even if an HRA reimburses only premiums.

Question 8: The interim final regulations regarding the annual dollar limit prohibition contain an exemption for health FSAs (as defined in Code § 106(c)(2)). See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). Does this exemption apply to a health FSA that is not offered through a Code § 125 plan?

Answer 8: No. The Departments intended for this exemption from the annual dollar limit prohibition to apply only to a health FSA that is offered through a Code § 125 plan and thus subject to a separate annual limitation under Code § 125(i). There is no similar limitation on a health FSA that is not part of a Code § 125 plan, and thus no basis to imply that it is not subject to the annual dollar limit prohibition.

To clarify this issue, the Departments intend to amend the annual dollar limit prohibition regulations to conform to this Q&A 8 retroactively applicable as of September 13, 2013. As a result, a health FSA that is not offered through a Code § 125 plan is subject to the annual dollar limit prohibition and will fail to comply with the annual dollar limit prohibition.

3. Guidance on Employee Assistance Programs

Question 9: Are benefits under an employee assistance program or EAP considered to be excepted benefits?

Answer 9: The Departments intend to amend 26 C.F.R. §54.9831-1(c), 29 C.F.R. §2590.732(c), and 45 C.F.R. §146.145(c) to provide that benefits under an employee assistance program or EAP are considered to be excepted benefits, but only if the program does not provide significant benefits in the nature of medical care or treatment. Excepted benefits are not subject to the market reforms and are not minimum essential coverage under Code § 5000A. Until rulemaking is finalized, through at least 2014, the Departments will consider an employee assistance program or EAP to constitute excepted benefits only if the employee assistance program or EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.

B. Guidance Under the Sole Jurisdiction of the Treasury Department and the IRS on HRAs and Code § 125 Plans

Question 10: Is an HRA that has fewer than two participants who are current employees on the first day of the plan year (for example, a retiree-only HRA) minimum essential coverage for purposes of Code §§ 5000A and 36B?

Answer 10: Yes. The Treasury Department and the IRS understand that some employers are considering making amounts available under standalone retiree-only HRAs to retired employees so that the employer would be able to reimburse medical expenses, including the purchase of an individual health insurance policy. For this purpose, the standalone HRA would constitute an eligible employer-sponsored plan under Code § 5000A(f)(2), and therefore the coverage would constitute minimum essential coverage under Code § 5000A, for a month in which funds are retained in the HRA (including amounts retained in the HRA during periods of time after the employer has ceased making contributions). As a result, a retiree covered by a standalone HRA for any month will not be eligible for a Code § 36B premium tax credit for that month. Note that unlike other HRAs, the market reforms generally do not apply to a retiree-only HRA and therefore would not impact an employer's choice to offer a retiree-only HRA.[10]

Question 11: How are amounts newly made available under an HRA treated for purposes of Code § 36B?

Answer 11: An individual is not eligible for individual coverage subsidized by the Code § 36B premium tax credit if the individual is eligible for employer-sponsored coverage that is affordable (premiums for self-only coverage do not exceed 9.5 percent of household income) and that provides minimum value (the plan's share of costs is at least 60 percent). 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 plan 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. Amounts newly made available for the current plan year under the HRA that an employee may use only to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan count only toward the minimum value requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations, to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). Amounts newly made available for the current plan year under the HRA that an employee may use to pay premiums or to pay both premiums and cost-sharing under the primary employer-sponsored plan count only toward the affordability requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013)

---

[10] See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010).

(proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)).

Even if an HRA is integrated with a plan offered by another employer for purposes of the annual dollar limit prohibition and the preventive services requirements (see Q&A 4 of this notice), the HRA does not count toward the affordability or minimum value requirement of the plan offered by the other employer. Additionally, 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.

For purposes of the Code § 36B premium tax credit, the requirements of affordability and minimum value do not apply if an employee enrolls in any employer-sponsored minimum essential coverage, including coverage provided through a Code § 125 plan, an employer payment plan, a health FSA, or an HRA, but only if the coverage offered does not consist solely of excepted benefits. See 26 C.F.R. §1.36B-2(c)(3)(vii). If an employee enrolls in any employer-sponsored minimum essential coverage, the employee is ineligible for individual coverage subsidized by the Code § 36B premium tax credit.

Question 12: Section 125(f)(3) of the Code, effective for taxable years beginning after December 31, 2013, provides that the term "qualified benefit" does not include any QHP (as defined in ACA § 1301(a)) offered through an Exchange.[11] This prohibits an employer from providing a QHP offered through an Exchange as a benefit under the employer's Code § 125 plan. Some states have already established Exchanges and employers in those states may have Code § 125 plan provisions that allow employees to enroll in health coverage through the Exchange as a benefit under a Code § 125 plan. If the employer's Code § 125 plan operates on a plan year other than a calendar year, may the employer continue to provide the Exchange coverage through a Code § 125 plan after December 31, 2013?

Answer 12: For Code § 125 plans that as of September 13, 2013 operate on a plan year other than a calendar year, the restriction under Code § 125(f)(3) will not apply before the first plan year of the Code § 125 plan that begins after December 31, 2013. Thus, for the remainder of a plan year beginning in 2013, a QHP provided through an Exchange as a benefit under a Code § 125 plan will not result in all benefits provided under the Code § 125 plan being taxable. However, individuals may not claim a Code § 36B premium tax credit for any month in which the individual was covered by a QHP provided through an Exchange as a benefit under a Code § 125 plan.

[11] This rule does not apply with respect to any employee if the employee's employer is a qualified employer (as defined in ACA § 1312(f)(2)) offering the employee the opportunity to enroll through an Exchange in a qualified health plan in a group market. See Code § 125(f)(3)(B).

IV. APPLICABILITY DATE AND RELIANCE PERIOD

This notice applies for plan years beginning on and after January 1, 2014, but taxpayers may apply the guidance provided in this notice for all prior periods. If legislative action by any State, local, or Indian tribal government entity is necessary to modify the terms of a pre-existing HRA, a health FSA that does not qualify as excepted benefits, an employer payment plan, or other similar arrangement, sponsored by any State, local, or Indian tribal government entity, as an employer, to avoid a failure to comply with the market reforms (including action to terminate such arrangement) and such action may only be taken by a State, local, or Indian tribal government entity legislative body, the applicability date of the portions of this notice under which such arrangement would otherwise fail to comply with the market reforms is extended to the later of (1) January 1, 2014, or (2) the first day of the first plan year following the first close of a regular legislative session of the applicable legislative body after September 13, 2013.

V. FOR FURTHER INFORMATION

The Departments have coordinated on the guidance and other information contained in this notice. The guidance in this notice is being issued in substantially identical form by DOL, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this notice. Questions concerning the information contained in this notice may be directed to the IRS at 202-927-9639, the DOL's Office of Health Plan Standards and Compliance Assistance at 202-693-8335, or HHS at 410-786-1565. Additional information for employers regarding the Affordable Care Act is available at www.healthcare.gov, www.dol.gov/ebsa/healthreform, and at www.business.usa.gov.