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Employee Benefits & Executive Compensation ADVISORY ■

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Agency Guidance Strikes a Major Blow for Individual Policy Premium Reimbursement and Stand-Alone Health Reimbursement Arrangements

On September 13, the IRS and the Department of Labor (DOL) issued twin notices—IRS Notice 2013-54 and Technical Release 2013-03 (collectively, the "Agency Guidance")[1]—which adversely affect an employer's ability to pay for major medical coverage issued in the individual market on a pre-tax basis and/or maintain a stand-alone defined contribution medical reimbursement plan, such as an HRA. The guidance created an explosion of interest within the employee benefits community with respect to such arrangements. This advisory provides an analysis of the Agency Guidance and its impact, including a summary reference chart of the arrangements that remain permissible and those that do not.

Practice Pointer: This advisory uses the term "IM Coverage" to refer to major medical coverage issued in the individual market, including such coverage offered inside *and* outside the federal and state public exchanges. "IM Coverage" does not include policies that qualify as "excepted benefits."

THE BOTTOM LINE

As discussed more fully below, the Agency Guidance precludes the use of any pre-tax funding mechanism to purchase IM Coverage for active employees (retiree-only coverage is discussed below). The Agency Guidance specifically addresses the use of health reimbursement arrangements (HRAs) to purchase IM Coverage, and also introduces a new term—"employer payment plan." The use of this new term is one reason the Agency Guidance has sparked so much discussion and potential confusion. As used in the Agency Guidance, the term "employer payment plan" is defined very broadly, and would include ***any*** pre-tax arrangement (including salary-reduction-funded cafeteria plans and premium reimbursement arrangements) used to purchase IM Coverage.

Practice Pointer: The Agency Guidance is generally effective for plan years beginning on or after January 1, 2014; however, there is language in the Agency Guidance that suggests that you cannot start a new plan year after September 13, 2013, if the arrangement is otherwise impermissible. We discuss the effective date issue in more detail below.

[1] IRS Notice 2013-54 may be found at http://www.irs.gov/pub/irs-drop/n-13-54.pdf and Technical Release 2013-03 may be found at http://www.dol.gov/ebsa/newsroom/tr13-03.html. HHS has confirmed its agreement with the DOL and IRS guidance in a bulletin issued on Sept. 16, 2013, which may be found at http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html#Employer Responsibility.

QUICK REFERENCE CHART

The following chart provides a quick reference guide as to the types of arrangements that are permissible in light of the Agency Guidance. More detail regarding the analysis underlying these conclusions is provided following the chart.

Type of Arrangement	Permissible or Not Permissible [2]	Comments
Employer-funded, tax free payment of IM Coverage. These are sometimes referred to as premium reimbursement HRAs or individual premium reimbursement accounts (PRAs). Some may refer to these as "61-146 arrangements." [3]	Not permissible	See below regarding the definition of "employer payment plan."
Payment of IM Coverage by employees with pre-tax salary reductions through a cafeteria plan	Not permissible	See below regarding definition of "employer payment plan." Some have questioned whether payment of IM Coverage through a cafeteria plan is permissible. Such an arrangement comes within the definition of an "employer payment plan" under the Agency Guidance, and thus appears to be prohibited.
Employer facilitation of after-tax payment of IM Coverage through payroll deduction	Permissible, but apparently only if not part of an employer-sponsored ERISA plan	Such an arrangement is permissible only to the extent ERISA's voluntary plan safe harbor is satisfied. *See* DOL Reg. 29 CFR § 2510.3-1(j).
An employer-funded defined contribution plan (DCP) for active employees that is not "integrated" with an employer's traditional (i.e., defined benefit) group health plan. Such a DCP might be referred to as a standalone HRA (if it allows a carryover) or a "MERP."	Not permissible	"Integrated" is a term of art defined specifically in the Agency Guidance. Even arrangements that are connected with an employer's defined benefit group health plan may fail to qualify as "integrated" if the rules in the Agency Guidance are not satisfied.

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[2] "Not permissible" means that the arrangement violates Public Health Service Act Section 2711 (prohibition on annual and lifetime dollar limits) and/or Section 2713 (required preventive services), each of which will trigger a $100 per day per affected beneficiary excise tax under Code Section 4980D. *See* "So what if I don't comply?" below for a more detailed discussion regarding the penalties. The Agency Guidance does NOT address the income tax exclusion associated with such arrangements.

[3] Revenue Ruling 61-146 provides that if an employer reimburses an employee for the cost of coverage for an individual market policy, the amount of the employer reimbursement may be excludable from gross income under Code Section 106. Similarly, if an employer pays an insurer directly for the cost of coverage under an individual market plan, the employer payment is also excludable under Code Section 106.

Type of Arrangement	Permissible or Not Permissible	Comments
A defined contribution medical expense reimbursement arrangement funded by non-cashable employer contributions and/or employee pre-tax salary reductions. These are often referred to as Health FSAs with employer credits.	Permissible if . . .	Such an arrangement will be permissible to the extent that it qualifies as an "excepted benefit." Although a Health FSA need not be integrated (as defined in the Agency Guidance) if it is an excepted benefit, the same employer who sponsors the Health FSA must make major medical coverage available to FSA eligible participants in order to qualify as an excepted benefit. Thus, a stand-alone Health FSA (i.e., where the employer does not also make major medical coverage available to eligible participants) is not permissible.
An employer-funded DCP for active employees that is "integrated" with an employer's defined benefit group health plan as defined in Q/A-4 of the Guidance	Permissible	The Agency Guidance creates a special definition of "integration," which focuses on both the scope of employees allowed to participate in the DCP and the scope of expenses eligible for reimbursement.
Employer-funded, tax-free payment of excepted benefit coverage (such as hospital indemnity or cancer coverage)	Permissible	Excepted benefits are not subject to the health insurance reforms at issue in the Agency Guidance.
Excepted benefit coverage funded by employees with pre-tax salary reductions	Permissible	
A DCP or premium reimbursement arrangement limited to former employees (e.g., retiree-only HRA)	Permissible	The health insurance reforms at issue do not apply to plans for which participation is limited to former employees. Note, if the plan covers rehired "retirees," the plan will be subject to the ACA reforms.

Practice Pointer: For purposes of this analysis, we use the terms "DCP" to mean any defined contribution arrangement that reimburses medical expenses, which may include, but is not limited to, premiums, and "PRA" to define arrangements that only reimburse premiums.

UNDERLYING BASIS FOR THE AGENCY GUIDANCE

The conclusions reached in the Agency Guidance and summarized above are a product of two health insurance reform provisions—PHSA Section 2711, which prohibits annual and lifetime dollar limits on essential health benefits (EHB),[4] and PHSA Section 2713,[5] which requires that non-grandfathered plans provide certain preventive services without cost-sharing.

The Agency Guidance does not affect arrangements that are not subject to these ACA requirements. Thus, the Agency Guidance does not impact HIPAA excepted benefits, so that accident, cancer, hospital indemnity policies and other excepted benefit coverage (e.g., certain limited-scope vision and dental) can still be funded on a pre-tax basis. In addition, the Agency Guidance does not affect plans that cover only former employees. Note that although such plans are commonly referred to as "retiree-only plans," the technical exception is for plans that do not cover any active employees. For example, stand-alone HRAs that cover no active employees may be used to purchase IM Coverage. However, if a stand-alone HRA covers re-hired "retirees," then the arrangement would not be permissible.

Practice Pointer: The Agency Guidance clarifies that an HRA for retirees will still qualify as minimum essential coverage as an eligible employer-sponsored plan as defined in Code Section 5000A. Thus, such coverage will disqualify a retiree from receiving a subsidy in the exchange even though it does not provide minimum value. Such coverage will satisfy the individual mandate.

The Agency Guidance treats plans that are integrated with a group health plan differently from plans that are not integrated with group health plans. Each of these situations is discussed separately below.

ARRANGEMENTS THAT ARE NOT INTEGRATED WITH A GROUP HEALTH PLAN

Many advocates of defined contribution (DC) health plan arrangements have suggested that a DC arrangement should be viewed in conjunction with the underlying IM Coverage when determining whether the ACA mandates are satisfied. The Agency Guidance concludes that such DC arrangements cannot be "integrated" with IM Coverage. Thus, because defined contribution plans and premium reimbursement arrangements would need to rely on the underlying IM Coverage purchased through the arrangement to satisfy PHSA Section 2711 and/or 2713, such arrangements are not permissible. In reaching this result, the Agency Guidance *reiterates* that HRAs and Health FSAs are group health plans subject to Sections 2711 and 2713 (unless otherwise exempt from the health insurance reforms such as under the limited HIPAA exception for certain health flexible spending arrangements).[6]

The Agency Guidance also provides a new term (an "employer payment plan") for employer pre-tax-funded IM arrangements.[7] An employer payment plan is defined as an arrangement that facilitates the direct or indirect payment (e.g., in accordance with Rev. Rul. 61-146) of IM Coverage premiums to the extent that such premiums are excluded from income under Section 106 of the Code. The Agency Guidance states that an employer payment plan does not include arrangements whereby employees may choose between cash or an *after-tax amount* to be applied toward

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4 A discussion regarding the definition of "essential health benefits" for purposes of this provision is beyond the scope of this advisory.

5 These sections, as well as other reforms added to the PHSA, are incorporated by reference into the Code and ERISA.

6 *See* Pg. 2 of TR 2013-03.

7 *See* Pg. 2 of TR 2013-03.

health coverage, including forwarding post-tax payroll deductions to the carrier, as long as the arrangement satisfies the voluntary plan safe harbor in DOL regulations (e.g., the employer does not endorse the IM Coverage by virtue of facilitating the after-tax payment or reimbursement). Thus, the Agency Guidance indicates that any arrangement that provides for the purchase of IM Coverage on a pre-tax basis will fail PHSA Sections 2711 and/or 2713.

Following is a discussion of common defined contribution arrangements and how they are impacted by the Agency Guidance.

- *Employer payment plan includes a cafeteria plan that allows payment of IM Coverage with pre-tax salary reductions*. Although cafeteria plans are not specifically mentioned in the definition of "employer payment plan," the definition is broad enough in scope to include cafeteria plans that facilitate the payment of IM Coverage. By definition, employer payment plans include arrangements that directly or indirectly pay premiums for IM Coverage where the premium payments are excluded from income under Code Section 106. Pre-tax salary reductions made through a cafeteria plan for accident and health insurance are excluded from income under Code Section 106. Perhaps more importantly, the only premium payment arrangements that the agencies make an effort to exclude from the employer payment plan definition are certain *after-tax* premium payment arrangements, and then only to the extent they meet the voluntary plan safe harbor rules under ERISA. Thus, the definition of employer payment plan would include pre-tax cafeteria plan arrangements (even those funded exclusively by salary reduction).

Practice Pointer: Does a "private exchange" that utilizes insured coverage issued in the ***group market*** violate Sections 2711 and 2713? No. The Agency Guidance merely indicates that defined contribution arrangements cannot be integrated with IM Coverage. However, if the coverage through a private exchange uses insurance policies issued to the employer through the group market, then it can be integrated with a defined contribution arrangement.

- *DCPs and PRAs cannot be integrated with IM Coverage for purposes of PHSA Section 2711*.[8] Since DCPs are group health plans, they are subject to Section 2711 unless otherwise exempted. The Agency Guidance clarifies that DCPs and PRAs cannot be integrated with IM Coverage for purposes of Section 2711.
- *The Section 106(c)(2) exception to PHSA Section 2711 is only applicable to Health FSAs offered through a cafeteria plan*.[9] The Section 2711 regulations exempt Code Section 106(c)(2) health flexible spending arrangements, so such arrangements could still presumably survive Section 2711 if they qualified as a Code Section 106(c)(2) health flexible spending arrangement. The Agency Guidance effectively shrinks this end-run around Section 2711 by indicating that future guidance will limit the Code Section 106(c)(2) exception to Section 2711 to Health FSAs offered through a cafeteria plan, and that this clarification will be retroactively effective to September 13, 2013. Since Health FSAs *offered through a cafeteria plan* cannot reimburse health insurance premiums, the agencies effectively close the door on PRAs.
- *DCPs and PRAs generally violate Section 2713, absent an exception*. Like Section 2711, the Agency Guidance indicates that a DCP and a PRA will violate Section 2713 (presumably, only if it is no longer grandfathered). The specific wording in the Agency Guidance with respect to this conclusion (Q-3) provides that the arrangement violates Section 2713 because it doesn't provide preventive services without cost-sharing *in all instances*. We believe that this language suggests that a DCP fails to satisfy Section 2713 even if it reimburses preventive care, because the annual contribution limit causes it to fail to cover required preventive care in all instances.

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8 *See* Q-1 of TR 2013-04.

9 *See* Q-8.

Practice Pointer: As noted above, Section 2711 provides an exception for Health FSAs offered through a cafeteria plan. Unfortunately, unless grandfathered, such a Health FSA would not satisfy Section 2713 in light of the Agency Guidance.

- *DCPs and PRAs cannot be integrated with IM Coverage for purposes of Section 2713*.[10] Much like the agencies did for purposes of Section 2711, the agencies clarify that a DCP and PRA cannot be integrated with the IM Coverage for purposes of Section 2713. Thus, DCPs and PRAs that are non-grandfathered will fail to satisfy Section 2713.

WHAT'S LEFT: ARRANGEMENTS THAT ARE INTEGRATED WITH A GROUP HEALTH PLAN

- DCPs (such as HRAs) that are "integrated" with an employer's compliant group health plan do not violate Section 2711 or 2713. A DCP is "integrated" if all of the following requirements are satisfied:
  - The employer offers the employee coverage under a group health plan (other than the DCP) that is not limited to excepted benefits.
  - Participation in the defined contribution arrangement is limited to those employees and dependents who also participate in an employer's defined benefit group health plan.

Practice Pointer: The Agency Guidance clarifies that participation in a DCP does not have to be limited to a 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 defined benefit group health plan ceases (e.g., if there is a spend-down provision).

Practice Pointer: A DCP that is integrated with a defined benefit 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 defined benefit plan.

  - If the scope of reimbursement under the DCP allows for reimbursement of anything other than the following expenses, then the defined benefit group health plan must provide minimum value coverage under the ACA rules:
    - copayments under an employer's group health plan;
    - coinsurance under an employer's group health plan;
    - deductibles under an employer's group health plan;
    - premiums under an 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]; and
    - benefits that are not essential health benefits.

Practice Pointer: Can a PRA be integrated with an employer's defined benefit group health plan? It appears at first glance that a PRA that paid for IM Coverage could be "integrated" to the extent that the employer's ACA-compliant defined benefit group health plan provides minimum value. However, the answer is somewhat unclear.

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[10] See Q-3.

– In addition, the Agency Guidance clarifies that an HRA 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*.

EFFECTIVE DATE ISSUES

The Agency Guidance provides that it is effective the first plan year that begins on or after January 1, 2014. A further extension applies to the applicability date for certain governmental and tribal plans until the first day of the first plan year after the close of the legislative session of the applicable legislative body after September 13, 2013.

Because the 2013 agency guidance does not specifically address its impact on the earlier FAQ guidance transition rule or its impact on HRAs that had previous waiver or class-exemption relief, its impact is unclear. Also, of specific interest to HRA sponsors who did not qualify for the FAQ transition rule, the waiver or class-exemption relief is the language that provides that the interim final regulation will be amended retroactively to September 13, 2013, to clarify that the Section 106(c)(2) FSA exemption is only applicable to FSAs offered through cafeteria plans.

Exactly how the above concepts should be integrated is unclear, and would seem to leave a number of different applicability dates for existing HRA arrangements. By way of example:

- HRAs eligible for the original HRA waiver or HRA class-exemption relief would seem to be allowed to continue until the end of the plan year (as in place when the waiver or exemption applied) that commences prior to January 1, 2014;
- Although unclear (due to language in the January FAQ referencing future guidance), it would seem that arrangements that satisfied the original January FAQ guidance transition rule could continue until December 31, 2013, with an allowable spend-down of accrued benefits; and
- HRAs that fail to qualify for waiver/class-exemption or the January FAQ transition relief should take heed of the September 13, 2013, effective date for the narrow interpretation of the 106(c)(2) FSA exception in the interim regulations. This may not mean, however, that they need to wind up their affairs prior to September 13, 2013. The annual cap prohibition is a plan-year limitation, and in the absence of further guidance, it may be reasonable to take the position that the narrower limitation applies to plan years on or after September 13, 2013.

Needless to say, further agency guidance on these transition issues would be welcome.

SO WHAT IF I DON'T COMPLY?

For private employers, failure to comply with the provisions of the Agency Guidance could result in the $100 per day per affected beneficiary excise tax imposed on failures to comply with health insurance reforms under Code Section 4980H. Presumably, each individual who offered an otherwise permissible arrangement is an affected beneficiary. While there is a cap on the 4980H of $500,000 for unintentional failures, no cap applies if the failure is intentional. CMS may impose a similar penalty on non-federal governmental employers.

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