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Important ACA Updates

November 12, 2013

Recently the Internal Revenue Service (IRS) and the Department of Labor (DOL) issued guidance clarifying how the Patient Protection and Affordable Care Act (PPACA) applies to Health Reimbursement Arrangements (HRAs), Health Care Flexible Spending Arrangements (FSAs), and certain other types of plans.

This guidance confirms and clarifies prior guidance. The following changes are for plan years starting or renewing after September 13, 2013.

Key provisions include:

- All HRAs should be designed as integrated HRAs. Stand-alone HRAs are no longer permitted. This means that you cannot have an HRA that is not attached directly to a group medical insurance plan.
- Health Reimbursement Arrangements (HRA) cannot impose a waiting period in excess of 90 days. Ninety days does not equal three months. Employers cannot have a 90-day waiting period with coverage effective the first day of the month following the 90-day waiting period.
- Health FSAs offered as part of a cafeteria plan must be designed as excepted benefits: 1) employer must provide group health (medical) coverage (insurance) and 2) employer contributions to the health FSAs must be at or below $500 or not more than a 100% match of employee contributions.
- Health Care Flexible Spending Accounts now have the option of allowing participants to roll over up to $500 of unused funds at the end of the plan year.
- Employers may no longer reimburse employees for individual health insurance coverage on a pre-tax basis unless the employer is participating in a SHOP (Small Business Health Options Program). This means that Premium Reimbursement Accounts are no longer permitted.

Health Reimbursement Arrangement (HRA)

Notice 2013-54 provides that "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." The notice

spells out two possible methods to provide an integrated HRA. The methods differ according to whether minimum value is required.

Minimum value generally means that a plan covers at least 60% of the total allowed cost of benefits. If an individual receives coverage that provides minimum value, he/she is generally not eligible for the premium tax credit unless the minimum value coverage is not affordable (costs more than 9.5% of his/her income).

The two integration methods are (**differences are highlighted in bold**):

1. Minimum Value Not Required.
    - The employer must offer other group health coverage (other than the HRA) **that does not consist solely of excepted benefits.**
    - Employees are only eligible for the HRA if they are actually enrolled in a group health plan (other than an HRA). The other group health plan can be offered by a different employer (such as the employee's spouse).
    - The HRA **must be limited to reimbursements of copays, co-insurance, deductibles, premiums, and medical care that does not constitute essential health benefits.**
    - An employee must be permitted to opt out of the HRA at least annually or to permanently opt out and waive all future reimbursements from the HRA. Upon termination, the remaining amounts in the HRA are forfeited.
2. Minimum Value Required.
    - The employer must offer other group health coverage (other than the HRA) **that provides minimum value.**
    - Employees are only eligible for the HRA if they are actually enrolled in a group health plan (other than an HRA) **that provides minimum value**. The other group health plan can be offered by a different employer (such as the employee's spouse).
    - **The HRA reimbursements are generally not limited** (other than being limited to health expenses under Code section 213(d)).
    - An employee (or former employee) must be permitted to opt out of the HRA at least annually or to permanently opt out and waive all future reimbursements from the HRA. Upon termination, the remaining amounts in the HRA are forfeited.

Group health plans are required to disclose whether the plan meets minimum value annually with its summary of benefits and coverage notice.

Health Reimbursement Arrangement (HRA) 90 Day Waiting Period

A waiting period is the period of time that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of the plan can become effective. Health Care Reform prohibits group health plans, which includes Health Reimbursement Arrangements (HRA), from imposing a waiting period in excess of 90 days. This means that any individual who meets the plan's eligibility requirements must be given the opportunity to commence coverage on or before the 91st day after the date the individual satisfies the eligibility requirements.

Health Care Flexible Spending Accounts (FSA) Rollover

This new guidance modifies the "use it or lose it" rule. An employer that sponsors a health FSA can choose to allow its employees to carry over unused amounts of up to $500 to use to reimburse qualified medical expenses incurred during the following year. Plan sponsors now have the choice of either allowing employees a carryover of up to $500 or allowing them a grace period of up to two and a half months (though employers are not required to allow either). A health FSA cannot, however, have both a carryover and a grace period. If you currently have a plan that doesn't offer the two and half month grace period you can adopt to allow the $500 rollover to the current plan year as long as your documents are changed before the last day of the plan. If you currently have the two and half month grace period you can change this and adopt the new rollover starting for any future plan year.

Flexible Spending Accounts (FSA) Employer Contribution

Cafeteria plans that offer health FSAs must be designed so that the benefits offered are excepted benefits: 1) the employer must provide other group health coverage and 2) employer contributions to the health FSA must be under $500 or not more that a 100% match of employee contributions.The following changes are for plan years starting or renewing after September 13, 2013.

Examples of Health FSA Funding That Meet the Maximum Benefit Condition:

- A one-for-one employer match (employer $600, employee $600).
- An employer contribution of $500 or less (employer $500, employee $200).
- An employer contribution of $500 or less, employee $0.

Examples of Health FSA Funding That Do Not Meet the Maximum Benefit Condition:

- An employer contribution of more than $500, if employee contributes $500 or less (employer $600, employee $400).
- An employer contribution in excess of one-to-one match, if employee contributes more than $500 (employer contributes $700, employee contributes $600).
- An employer contribution of $600 (employee $0) for an employee waiving medical coverage.

Health FSAs funded exclusively by employee salary reduction contributions (with annual coverage capped by the amount of the annual salary reduction election) will, by definition, satisfy the Maximum Benefit Condition.

One issue not addressed in the guidance is whether a health FSA with a carryover feature of $500 that also has employer contributions can continue to qualify as an excepted benefit under HIPAA (and thus also remain exempt from health reform). Pending further guidance, we advise against adopting a carryover feature if you also provide employer contributions.

Premium Reimbursement Arrangement (PRA)

Premium reimbursement arrangements are now called "employer payment plans." An employer payment plan is any arrangement under which an employer reimburses an

employee for all or part of the premium for an individual health policy. Employer payment plans include reimbursement of substantiated employee premium payments and direct employer payment to the insurance carrier. Like stand-alone HRAs, employer payment plans will not meet the PPACA requirements of no dollar limits or coverage of preventive care, and so will not be allowed after Dec. 31, 2013.

The Notice states that an employer payment plan 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." This would seem to mean that paying pre-tax premiums through a Section 125 plan for individual coverage would be considered an employer-payment plan and will not be allowed after this year. Note that cafeteria plans may still forward pre-tax contributions for group health plan coverage purchased in a state or federal Marketplace SHOP Exchange.

The above information is Benefit Strategies' translation of the IRS regulations. You may also want to consult your tax professional to discuss which method is best for you organization. For more information from the IRS please refer to the following links:

IRS Notice 2013-54
DOL Technical Release 2013-03

If you would like to talk about plan changes or adjustments please contact your Account Manager. If you don't know your Account Manager please contact us at 888-401-3539.

Please contact Benefit Strategies at our toll free number for more information.

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