New ACA Guidance Complicates Use of HRAs and Other Account-Based Plans

The federal agencies implementing the Patient Protection and Affordable Care Act (PPACA, or ACA) have issued additional guidance detailing the future of account-based/defined contribution health plans, such as health reimbursement arrangements (HRAs), health flexible spending accounts (FSAs) and programs under which employers pay or reimburse the cost of individual insurance policies (employer payment programs, or EPPs).

The new guidance turns what were, prior to the ACA, simple and straightforward healthcare reimbursement programs into convoluted endeavors some employers won’t want to undertake. Sadly, the guidance eviscerates the use of HRAs to help pre-Medicare retirees offset premium or out-of-pocket expenses incurred under individual health insurance policies they may have hoped to purchase in a public health insurance exchange/marketplace with federal subsidies.

HRAs and Their Hobbled Future under Health Reform

An HRA is a reimbursement arrangement funded solely by the employer (i.e., no pretax employee contributions under Tax Code Section 125’s “cafeteria plan” rules). HRAs may reimburse an employee for tax-qualified medical expenses (including premiums) incurred by the employee, his or her spouse, and children through the year in which the children attain age 26. Typically, HRAs have annual dollar limits on reimbursements.

HRAs and other account-based health programs are problematic under the ACA’s prohibition on dollar limits for essential health benefits because, by their nature, they provide benefits limited to a specific dollar amount. Prior guidance from the agencies indicated that retiree-only HRAs are not subject to the dollar limit prohibition because the ACA’s market reforms don’t apply to retiree-only coverage, or to “excepted benefits,” such as most dental and vision plans and most health FSAs.

Lockton Comment: An employer might choose to structure the HRA itself as an excepted benefit, by restricting reimbursements to dental and vision expenses.
But typical HRAs for active employees enjoy no such dodge, and the prior guidance concluded that such HRAs for employees survive after 2013 only if “integrated” with group medical coverage. The new rules provide detailed tests to determine if an HRA is “integrated.”

Under the recent guidance, an HRA is considered “integrated” with other medical coverage if all of the following are true:

1. **The employer offers other group coverage** (something more robust, for example, than an excepted benefit, such as most dental and vision plans or most health flexible spending accounts).

2. **The employee covered by the HRA is actually enrolled in group coverage in addition to the HRA** (the other group coverage must again be more robust than an excepted benefit). In addition, the terms of the HRA must reflect that only employees enrolled in other group coverage are eligible for HRA benefits.

   **Lockton Comment:** Fascinatingly, while for purposes of the *first* bulleted item above the employee’s employer must offer other group coverage, for purposes of this *second* bulleted item, the group coverage in which the employee is actually enrolled can be *any* group plan, sponsored by *anyone* (for example, a spouse’s employer, a jointly-trusteed multiemployer plan, etc.). In sum, the HRA and the group coverage with which it is deemed “integrated” need not be offered under the same plan, or even by the same employer.

   Note that if an employer is going to offer an HRA and allow it to “integrate” with another employer’s group coverage, the HRA-sponsoring employer should probably require an employee, when submitting a claim to the HRA, to attest that he or she is enrolled under group coverage someplace else.

3. **The HRA’s reimbursements are limited to one or more of the following:** copayments, coinsurance, deductibles and premiums under the other group coverage, as well as medical care that does not constitute an “essential health benefit” under the ACA. This requirement does not apply, however, if the other group coverage supplies at least “minimum value” coverage, that is, coverage with a least a 60-percent actuarial value.

   **Lockton Comment:** This restriction on the type of expenses an integrated HRA may reimburse—particularly the reference to medical care that doesn’t constitute an “essential health benefit”—is peculiar, but what the agencies are trying to avoid is a fraying of the required “integration” between the HRA and the group plan.

   For example, assume a group major medical plan covers all essential health benefits. The ACA prohibits the group plan from imposing dollar limits on those benefits. But what if the plan fails to cover a particular essential health benefit—prescription drugs, for example—but the HRA reimburses prescription drug expenses? The HRA, by its nature, provides limited annual benefits. Thus, the prescription drug benefit offered by the employer under the combined group
plan/HRA arrangement would have an annual dollar limit, something the ACA does not permit.

Again, however, this restriction on reimbursements does not apply if the other group coverage is at least “minimum value” coverage, which will often be the case.

4. **The HRA permits a covered employee or former employee to choose, at least annually, to permanently opt out of the HRA.** This same opt-out offer must be made at termination of employment unless the HRA balances are forfeited upon termination.

**Lockton Comment:** The reason the agencies want HRAs to allow covered individuals to opt out is because HRA coverage is typically “minimum essential coverage,” sufficient under the ACA to satisfy the individual mandate and insulate the employer from all penalties under the ACA’s employer mandate, but also sufficient to strip the individual of eligibility for subsidies in a public health insurance exchange.

The “opt-out” right is, then, a federal safeguard against employers who might unilaterally cover employees under a skimpy HRA just to insulate themselves from potential penalties, while freezing the employees out of potentially more robust, heavily subsidized coverage through an insurance exchange.

Also importantly, the recent rules reiterate prior guidance that an HRA or other account-based program can never be considered “integrated” with *individual* market coverage, meaning an HRA or EPP designed to reimburse the cost of individual coverage for employees simply can’t survive after 2013.

Retirees under a *retiree-only* HRA or EPP may continue to receive tax-free reimbursements of the cost of an individual insurance policy, because the program would not need to be “integrated” to survive. But the recent guidance provides that those HRA reimbursements would be considered “minimum essential coverage” under the ACA, depriving the retiree of eligibility for subsidies in a public health insurance exchange.

**Lockton Comment:** An individual is not eligible for subsidies in a public health insurance exchange if he or she is *eligible* for employer-based coverage considered both “minimum value” and “affordable,” or *enrolled* in “minimum essential coverage,” without regard to its actuarial value or affordability. Individuals eligible for Medicare are also ineligible for subsidies. By concluding that coverage under an HRA is “minimum essential coverage,” federal regulators have barred HRA-enrolled, pre-Medicare retirees from obtaining subsidized insurance in a public health insurance exchange.

So what’s an employer and its pre-Medicare retirees to do with HRA programs after 2013? One possibility is to restrict the HRA to reimbursing dental and vision expenses, in essence converting the HRA to an excepted benefit. Coverage under an excepted benefit is not “minimum essential coverage.” Another possibility is suspending the retiree’s HRA coverage until he or she qualifies for Medicare (the retiree could then use the benefits to...
fund Medicare supplement policies, or reimburse out-of-pocket expenses not covered by Medicare). A third option might be requiring the retiree to affirmatively “opt in” to the HRA in order to be considered covered; retirees with low incomes, who would reap the largest subsidies in a public exchange, would simply choose not to opt in.

Note, however, that if the employer is offering HRAs to retirees, to defray the cost of individual coverage under a private insurance exchange, as large employers such as IBM and Time Warner recently announced they intend to do, nothing in the recent guidance frustrates those efforts.

**Premium Payment Accounts under Health Reform**

We’ve noted above the impact the recent guidance has on employer payment programs (EPPs), such as programs under which an employer directly pays for, or reimburses the employee for the cost of, an individual health insurance policy. Such programs for employees die on the vine after 2013, because they inherently include dollar limits, and can’t be considered “integrated” with individual coverage.

We want to take a moment here to comment on another kind of EPP: premium payment accounts. Pre-health reform IRS guidance had authorized employees to fund, on a pre-tax basis, a “premium payment account” under a Section 125 plan. The employees could then reimburse themselves, from the accounts, for the purchase of individual health insurance policies. These accounts operated like employee-funded health FSAs, but were for the purchase of individual insurance coverage.

The ACA has always prohibited employers from offering individual, public exchange-based coverage as a pretax benefit under a Tax Code section 125 cafeteria plan. Employers who have maintained premium payment accounts under their cafeteria plans, however, have wondered whether employees could use these funds to reimburse themselves, on a tax-free basis, for such individual coverage. We have presumed the answer was “no,” but not until the issuance of the recent guidance did the feds confirm that the answer is, indeed, “no.”

**Health FSAs under Health Reform: Watch Employer Contributions Greater than $500, or Allowing Coverage for Employees Ineligible for Other Coverage**

Not much new news here. Health FSAs, of course, are arrangements under Tax Code section 125, typically funded by pretax employee contributions, that reimburse healthcare expenses incurred by the employee, his or her spouse, and children through the year in which they attain age 26.

In contrast to an HRA, FSAs can be funded by both employees and the employer. However, FSAs cannot be used to reimburse for premium payments and are subject to a cap on employee pretax contributions of $2,500 per year, adjusted for inflation after 2013. We commented on these rules in an Alert published June 1, 2012.

Generally speaking, FSAs are considered an excepted benefit—and thus dodge the ACA’s market reform rules and restrictions—if they are offered only to employees who are also offered other
health coverage by the employer, and the employer contribution, if any, to any employee’s FSA
doesn’t exceed $500 for the year.

This test is easy to satisfy for most employer programs: The FSA is typically offered in
conjunction with major medical coverage (satisfying the first qualification above), and the
employer rarely contributes to the FSA. Rather, the employee’s reimbursement is almost always
limited to the amount of projected pretax contributions the employee chooses to make
(satisfying the second qualification above).

The recent guidance merely reiterates that FSAs dodge the ACA’s market reforms as long as
they operate as excepted benefits, and become problems for the employer the moment they
don’t.

**Lockton Comment:** We’ve counseled employers for years to not to let their FSAs lose
excepted benefit status. Losing that status causes problems under health reform, plus it
subjects the health FSA to much more extensive and onerous rules under COBRA, and
to the HIPAA portability rules.

**Some Good News: EAPs as Excepted Benefits**

The agencies did give employers one kernel of good news with the recent guidance. Employee
assistance plans (EAPs) that do not provide significant medical benefits will be treated as
excepted benefits, and thus are not subject to the dollar limit prohibition or other ACA market
reforms, at least through the end of 2014. For now, employers can use a reasonable, good faith
interpretation of what qualifies as significant benefits.

**Effective Date**

The new rules will apply to plan years beginning on or after Jan. 1, 2014, but can be relied on
before then.

**Guidance at a Glance**

Please review the handy table below for a summary of qualifications for account-based
coverage, as stipulated in the new guidance.

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Edward Fensholt, J.D. and Mark Holloway, J.D.
Compliance Services Division

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# Reimbursement Programs under the ACA: Recent Guidance at a Glance

<table>
<thead>
<tr>
<th>Subject to ACA’s market reforms, such as annual dollar limit prohibition?</th>
<th>HRAs</th>
<th>EPPs</th>
<th>FSAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, for “integrated” HRAs for employees.</td>
<td>Yes, for employees; EPPs for employees are prohibited after 2013.</td>
<td>No, if structured as an excepted benefit.</td>
<td></td>
</tr>
<tr>
<td>Yes, for non-integrated HRAs for employees; non-integrated HRAs for employees are prohibited after 2013.</td>
<td>No, for HRAs structured as excepted benefits (e.g., limited to dental and vision expenses).</td>
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<tr>
<td>No, for retiree-only HRAs.</td>
<td>No, for retiree-only EPPs.</td>
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<tr>
<th>Qualifies as “minimum essential coverage” for purposes of the “individual mandate”?</th>
<th>HRAs</th>
<th>EPPs</th>
<th>FSAs</th>
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</thead>
<tbody>
<tr>
<td>Yes, but is a moot point with respect to employees (the group coverage with which the HRA must be integrated is also minimum essential coverage).</td>
<td>Yes, for employees and retirees</td>
<td>No, if structured as an excepted benefit.</td>
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<tr>
<td>Yes, for retirees, whether or not the HRA is integrated.</td>
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<tr>
<td>No, for HRAs structured as “excepted benefits” (e.g., limited to dental and vision expenses).</td>
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<tr>
<th>Disqualifies the covered individual from subsidies in a public insurance exchange?</th>
<th>HRAs</th>
<th>EPPs</th>
<th>FSAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, for employees, retirees and covered dependents, unless the HRA is structured as an excepted benefit (e.g., limited to dental and vision expenses).</td>
<td>Yes, for employees and retirees.</td>
<td>No, if structured as an excepted benefit.</td>
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</tbody>
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<thead>
<tr>
<th>Requirements for “integration”</th>
<th>HRAs</th>
<th>EPPs</th>
<th>FSAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer offers other group coverage.</td>
<td>Not applicable; integration not possible.</td>
<td>Not applicable for FSAs structured as an “excepted benefit.”</td>
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<tr>
<td>HRA requires the employee to be enrolled in other group coverage (even if through another employer or sponsor).</td>
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<tr>
<td>HRA reimbursements limited to deductibles, copayments, coinsurance and/or premiums under the group coverage; and to nonessential health benefits (non-EHB requirement waived if group coverage supplies “minimum value”).</td>
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<tr>
<td>HRA offers opt-out right annually, and at termination unless HRA balance is forfeited at termination.</td>
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