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

On September 13, 2013, the IRS and DOL issued guidance (the Agency Guidance) addressing the impact of certain provisions of the Affordable Care Act (ACA) on defined contribution arrangements (including HRAs and individual medical policy arrangements). This guidance dramatically changes the landscape for employer sponsored arrangements that make coverage available through individual medical (IM) policies by prohibiting tax free funding of IM coverage for active employees. Due to its complexity, however, there has been a great deal of misunderstanding as to the scope of the Agency Guidance. This article provides important clarification that every agent, broker, and benefit advisor needs to know in assisting their employer clients.

Important Notice

The general information and discussion below is provided to assist counsel for employers 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. It is not intended as legal, financial or tax advice from NAHU or Alston & Bird, LLP, and neither NAHU nor Alston & Bird, LLP makes any warranties concerning the contents. Employers and agents/brokers should seek the advice of their independent legal counsel to determine the application of IRS Notice 2013-54 to their own specific circumstances.

IRS Circular 230 disclosure: Any U.S. federal tax advice contained in this communication (including any attachments) is not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties that may be imposed on any taxpayer or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

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—IRS Notice 2013-54 and Technical Release 2013-03 (collectively, the Agency Guidance). 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 the premiums to the carrier directly or whether the individual is reimbursed 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 excludable 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.
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 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	Permissible	Direct payment or

payment or reimbursement of premiums for policies that provide "excepted benefits". **NOTE: Recent 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.**		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.
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	Likely Permissible	Confirming IRS guidance as to a "stand-alone arrangement would be

arrangement that reimburses only dental and vision expenses (but NOT preventive care expenses). These are often referred to as limited purpose HRAs.		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.
Employer-funded, payments or reimbursements of any 213(d) expense, including	Permissible	The Agency Guidance does not affect arrangements established solely for

premiums for IM Coverage, through arrangement limited to retirees. These are often referred to as Retiree HRAs or Retiree Reimbursement Accounts.		former employees.

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.

II. 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.

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

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

- 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 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 and satisfy such requirements. See Questions 2, 4-6 of the Agency Guidance.

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.

III. 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 commonly referred to as HRAs 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 a newly defined arrangement, the "employer payment plan." 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 pay IM Coverage with pre-tax salary reductions.[2] 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 in and of itself. 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. Arrangements that facilitate the payment or reimbursement of premiums do not qualify as excepted benefit plans (see Appendix A for a summary of the excepted benefit plans). Consequently such arrangements are subject to Section 2711 unless 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

[2] 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.

concludes that such arrangements violate Section 2711, the agencies are necessarily concluding that such arrangements provide essential health benefits.

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 you avoid this problem by agreeing to pay for all IM Coverage premiums that you have. 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.[3]

- 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, an arrangement is exempt from 2711 if it is integrated with an arrangement that complies with Section 2711. The Agency Guidance quickly closes this potential door by indicating that the arrangement cannot be integrated with the IM Coverage; thus requiring other ACA compliant group health coverage that provides minimum value coverage (under the Agency Guidance integration rules).

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**

[3] 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.

employer's group health plan that provides minimum value (without regard to the coverage provided by the arrangement).[4] As a threshold matter, an arrangement is integrated with an employer's group health plan if participation in the arrangement is limited to employees who participate in the employer's group health plan (other than a defined contribution arrangement). As a result, this arrangement seems to lack practical value because it would mean that the employee would have both comprehensive group health plan coverage through the employee's or spouse's employer AND major medical coverage issued in the individual market. In addition, since the employer's group health plan must provide minimum value, the arrangement would not be considered integrated with a so-called skinny plan.

- 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 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, which includes but is not limited to HRAs and employer payment plans.

The Agency Guidance effectively closes each and every door to the pre-tax payment or reimbursement of IM Coverage premiums.

[4] Also, the minimum value rules indicate that a group health plan can consider the benefits provided by an HRA (or other defined contribution arrangement) 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.

- 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, as prescribed by the Agency Guidance. [5]

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).
- 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

[5] 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.

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.[6]

[6] 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."

- 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 (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.

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.[7]

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.

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

About the Authors

John R. Hickman

John Hickman is head of the Alston & Bird, LLP Health Benefits Practice where he leads an experienced team of attorneys devoted exclusively to health care reform issues under the ACA, HIPAA privacy, flexible benefits, and other health & welfare benefit issues. Mr. Hickman has been a pioneer in the consumer directed health care arena and has worked closely with health plans, financial institutions, and employers as well as the IRS, Treasury, and DOL with respect to tax-favored health reimbursement arrangements (HRAs) and health savings accounts (HSAs).

Mr. Hickman is a fellow of the American College of Employee Benefits Counsel, and has been listed in *The Best Lawyers in America* (Woodward/White) and *Who's Who Legal* in the employee benefits area. Mr. Hickman has lectured widely and published articles on HSAs, HIPAA, ERISA litigation, cafeteria and health plan issues. He is co-author of the *Cafeteria Plans Manual*, *Health Care Reform*, *HIPAA Portability and Privacy*, and *Consumer-Driven Health Care* (published by the Employee Benefits Institute of America). Mr. Hickman is head of the Technical Advisory Committee and is on the board of the Employers Council on Flexible Compensation (ECFC). Mr. Hickman is also an adjunct professor of law at Emory University School of Law.

Ashley Gillihan

Ashley Gillihan is a member of Alston & Bird's Employee Benefits and Executive Compensation Group. Mr. Gillihan represents various corporate plan sponsors, insurers, HSA trustee/custodians, financial institutions and third party benefit plan administrators.

Mr. Gillihan lectures frequently and has published various articles on health and welfare benefit plan related topics. He is a faculty member for MCOL (a managed health care on-line organization) and the Institute of Applied Management and Law (IAML). He is a member of the Advisory Board of Editors of the Benefits Compensation Law Alert and the Technical Advisory Council to the Employer's Council on Flexible Compensation. He is also the primary author of the Flexible Benefits Answer Book by Aspen Publishers.