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CLIENT ALERT

Labor Department Issues Guidance That Muddies the Waters for Employers Offering Health Reimbursement Arrangements, Health Flexible Spending Accounts, and Employee Assistance Programs

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On September 13, 2013, the U.S. Department of Labor ("DOL") published Technical Release 2013-03 ("Technical Release"), which provides guidance on the application of certain provisions of the Patient Protection and Affordable Care Act, as amended by the Health Reform and Education Reconciliation Act of 2010 ("Affordable Care Act"), to specific types of health reimbursement arrangements and employee assistance programs ("EAPs") sponsored by employers. The U.S. Treasury simultaneously issued guidance in substantially identical form to the Technical Release under Internal Revenue Service ("IRS") Notice 2013-54 and, on September 16, 2013, the U.S. Department of Health and Human Services ("HHS") published an information memorandum stating that the HHS concurs with the guidance issued by the DOL and IRS.

This guidance is significant for employers that wish to offer assistance to employees by paying or reimbursing the costs of premiums, cost-sharing, and qualified medical expenses. The Technical Release is effective for plan years beginning on and after January 1, 2014.

The principal issues under the Affordable Care Act, as framed by the DOL in the Technical Release, are whether the health benefits, payments, or reimbursements offered by employers under certain arrangements violate (1) the prohibition of annual dollar limits on essential health benefits, and (2) the requirement that non-grandfathered group health plans offer preventive services without cost-sharing. The concern is that such health payment or reimbursement arrangements violate the prohibition of annual dollar limits because, by their very nature, payments or reimbursements only can be made up to a fixed amount. Such arrangements also do not pay or reimburse preventive services without cost-sharing in all instances.

Health Reimbursement Arrangements ("HRAs")

HRAs are generally considered group health plans and are arrangements fully funded by the employer for the purpose of reimbursing the employee for medical care expenses incurred by the employee or his or her spouse or dependents up to a maximum dollar amount for a coverage period. For example, an HRA may allow an employee to submit claims for reimbursement of medical expenses up to $2,000 annually each plan year. HRAs are permitted to reimburse individual premium costs (but health FSAs, as defined below, are not).

Under the Technical Release, HRAs will not be treated as violating the annual dollar limit prohibition or preventive services requirements if the HRA is "integrated" with a group health plan. Prior DOL FAQs (frequently asked questions) stated that an employer-sponsored HRA and other types of group health plan coverage *cannot* be integrated with individual market coverage for purpose of compliance with the annual dollar limit prohibition and preventive services requirement. This requirement also applies to employer payment plans that pay directly for, or reimburse insurance premiums purchased as, individual market coverage on behalf of employees. The Technical Release makes clear that employer-paid reimbursement arrangements or employer payment plans may *not* be used for the purpose of reimbursing employees for individual coverage purchased through the Health Insurance Marketplace, on a private exchange, or directly from the carrier. These arrangements are no longer viable options for employers as they fail to both comply with the annual dollar limit prohibition and meet the preventive services requirement.

To avoid the application of the market reforms, employers should ensure that an HRA is integrated with a group health plan. The Technical Release describes two types of "integration methods" that an employer could rely upon, the first where minimum value is not required and the second requiring minimum value. Set forth below is a table that outlines the requirements for both integration methods.

1. Minimum Value Not Required	**2. Minimum Value Required**
An employer offers a group health plan other than the HRA that does not consist solely of "excepted benefits" ("group health plan")	An employer offers a group health plan other than the HRA that provides minimum value ("MV group health plan")
The employee receiving the HRA is enrolled in a group health plan of the employer or another employer, e.g., group health plan coverage under a spouse's plan that does not consist solely of excepted benefits ("non-HRA group coverage")	The employee receiving the HRA is enrolled in a MV group health plan of the employer or another employer, e.g., MV group health plan coverage under a spouse's plan ("non-HRA MV group coverage")

1. Minimum Value Not Required	2. Minimum Value Required
The HRA may only be available to employees who enroll in non-HRA group coverage	The HRA may only be available to employees who enroll in non-HRA MV group coverage
The HRA is limited to reimbursement of one or more of: • Co-payments • Co-insurance • Deductibles • Premiums under the non-HRA group coverage • Medical care (other than essential health benefits)	Not required
An employee and a former employee must be permitted to permanently opt out of the HRA or waive future reimbursements from the HRA at least annually and, upon termination of employment, the former employee must either forfeit or opt out[1]	An employee and a former employee must be permitted to permanently opt out of the HRA or waive future reimbursements from the HRA at least annually and, upon termination of employment, the former employee must either forfeit or opt out

If an employee is not enrolled in the employer's group health plan, but is enrolled in other non-HRA group coverage, the employer may rely on the employee's attestation that the employee is covered by that other employer's non-HRA group coverage. Under the first integration method, the employee also will need to attest that the reimbursement of the HRA is limited to co-payments, co-insurance, etc., and under the second integration method, the employee will need to attest that the non-HRA group coverage provides minimum value.

If an employee ceases to be covered under integrated group health plan coverage, the employee may use the remaining amounts in the HRA to reimburse medical expenses in accordance with the terms of the HRA. However, an HRA will violate the annual dollar limit prohibition if the integrated group health plan does not cover a category of essential health benefits and the HRA is available to cover that category up to the maximum benefit.

[1] The continued right to participate in the HRA will preclude the former employee's eligibility for claiming a premium tax credit.

Health Flexible Spending Accounts ("Health FSAs")

Health FSAs reimburse employees for medical care expenses incurred by the employee or his or her spouse or dependents and are group health plans that may be considered to provide excepted benefits. There is a general exception to the market reforms for health FSAs that qualify as excepted benefits when the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to a participant does not exceed two times the participant's salary reduction election under the health FSA for the plan year (or, if greater, $500 plus the amount of the participant's salary reduction). A health FSA that does not qualify as an excepted benefit could not be integrated with a group health plan and, therefore, would be subject to the preventive services requirements.

There also is a general exemption from the annual dollar limit prohibitions for health FSAs, regardless of whether the health FSA is considered to provide only excepted benefits. The Technical Release makes clear that the health FSA must be offered under a cafeteria plan within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), to meet the exemption from the annual dollar limit prohibition. In any event, a health FSA that does not qualify as excepted benefits will fail to meet the preventive care services requirement.

Employee Assistance Programs

The Technical Release provides that benefits offered under an EAP are excepted benefits not subject to the market reforms, unless the program provides "significant benefits in the nature of medical care or treatment." Until rulemaking is finalized, employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment.

Retiree-Only HRAs and Premium Tax Credits

A stand-alone retiree-only HRA (i.e., offered to fewer than two participants who are current employees on the first day of the plan year) could reimburse a retiree for medical expenses, including the purchase of an individual health insurance policy. Although such retiree-only HRA would be considered minimum essential coverage for purposes of eligibility for the premium tax credit on the exchanges, the market reforms do not apply to retiree-only HRAs.

Employees whose employer offers group health coverage that is affordable and provides minimum value are not eligible to receive a premium tax credit on an exchange. The Technical Release makes clear that amounts newly made available under an HRA that is integrated with the employer's group health plan may count towards determining whether either the affordability or minimum value requirement (but not both) is met.

Amounts newly made available under the HRA that are only used to reduce cost-sharing for covered medical expenses only count towards minimum value. Amounts that may only be used for the payment of premiums or the payment of premiums and cost-sharing only count towards the affordability requirement. If the HRA is integrated with a different employer's group health plan or if the employer offers an HRA on the condition that the employee does not enroll in the employer-sponsored non-HRA group coverage, the HRA does not count towards either requirement.

Now is the time to review existing reimbursement arrangements and EAPs to identify any compliance gaps with the Affordable Care Act.

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