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U.S. Department of Labor

Employee Benefits Security Administration
Washington, D.C. 20210



TECHNICAL RELEASE 2013-03

DATE: SEPTEMBER 13, 2013

SUBJECT: APPLICATION OF MARKET REFORM AND OTHER PROVISIONS OF THE AFFORDABLE CARE ACT TO HRAS, HEALTH FSAs, AND CERTAIN OTHER EMPLOYER HEALTHCARE ARRANGEMENTS

I. PURPOSE AND OVERVIEW

This Technical Release provides guidance on the application of certain provisions of the Affordable Care Act¹ to the following types of arrangements: (1) health reimbursement arrangements (HRAs), including HRAs integrated with a group health plan; (2) 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); and (3) certain health flexible spending arrangements (health FSAs). This Technical Release also provides guidance on section 125(f)(3) of the Internal Revenue Code (Code) and on employee assistance programs or EAPs.

The Departments of the Treasury (Treasury Department), Health and Human Services (HHS), and Labor (DOL) (collectively, the Departments) are continuing to work together to develop coordinated regulations and other administrative guidance to assist stakeholders with implementation of the Affordable Care Act. The guidance in this Technical Release is being issued in substantially identical form by the Treasury Department, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this Technical Release.

II. BACKGROUND

A. HEALTH REIMBURSEMENT ARRANGEMENTS

An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Code § 213(d)) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. IRS Notice 2002-45,

¹ The "Affordable Care Act" refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148) (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10).

2002-02 CB 93; Revenue Ruling 2002-41, 2002-2 CB 75. This reimbursement is excludable from the employee's income. Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years. HRAs generally are considered to be group health plans within the meaning of Code § 9832(a), § 733(a) of the Employee Retirement Income Security Act of 1974 (ERISA), and § 2791(a) of the Public Health Service Act (PHS Act) and are subject to the rules applicable to group health plans.

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 Technical Release, 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) are met.

C. HEALTH FLEXIBLE SPENDING ARRANGEMENTS (HEALTH FSAS)

In general, a health FSA is a benefit designed to reimburse employees for medical care expenses (as defined in Code § 213(d), other than premiums) incurred by the employee, or the employee's spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.125-5); Code §§ 105(b) and 106(f). Contributions to a health FSA offered through a cafeteria plan satisfying the requirements of Code § 125 (a Code § 125 plan) do not result in gross income to the employee. Code § 125(a). While employees electing coverage under a health FSA typically also elect to enter into a salary reduction agreement, employers may provide additional health FSA benefits in excess of the salary reduction amount. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43955-43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §§1.125-1(r), 1.125-5(b)). For plan years beginning after December 31, 2012, the amount of the salary reduction is limited by Code § 125(i) to \$2,500 (indexed annually for plan years beginning after December 31, 2013). See IRS Notice 2012-40, 2012-26 IRB 1046, for more information about the application of the limitation. Additional employer contributions are not limited by Code § 125(i).

The Code, ERISA, and the PHS Act impose various requirements on group health plans, but certain of these requirements do not apply to a group health plan in relation to its provision of excepted benefits. Code § 9831(b), ERISA § 732(b), PHS Act §§ 2722(b) and 2763. Although a health FSA is a group health plan within the meaning of Code § 9832(a), ERISA § 733(a), and PHS Act § 2791(a), a health FSA may be considered to provide only excepted benefits if other group health plan coverage not limited to excepted benefits is made available for the year to employees by the employer, but only if the arrangement is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of

the participant's salary reduction election). 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. §146.145(c)(3)(v).

D. AFFORDABLE CARE ACT GUIDANCE

1. MARKET REFORMS – IN GENERAL

The Affordable Care Act contains certain market reforms that apply to group health plans (the market reforms).² In accordance with Code § 9831(a)(2) and ERISA § 732(a), the market reforms do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year, and, in accordance with Code § 9831(b), ERISA § 732(b), and PHS Act §§ 2722(b) and 2763, the market reforms also do not apply to a group health plan in relation to its provision of excepted benefits described in Code § 9832(c), ERISA § 733(c) and PHS Act § 2791(c).³ Excepted benefits include, among other things, accident-only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and certain health FSAs.

The market reforms specifically addressed in this Technical Release are:⁴

(a) PHS Act § 2711 which provides that a group health plan (or a health insurance issuer offering group health insurance coverage) may not establish any annual limit on the dollar amount of benefits for any individual—this rule does not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing an annual limit, with respect to any individual, on specific covered benefits that are not essential health benefits⁵ to the extent that such limits are otherwise permitted under applicable law (the annual dollar limit prohibition); and

(b) PHS Act § 2713 which requires non-grandfathered group health plans (or health insurance issuers offering group health insurance plans) to provide certain preventive services without imposing any cost-sharing requirements for these services (the preventive services requirements).

² Section 1001 of the ACA added new PHS Act §§ 2711-2719. Section 1563 of the ACA (as amended by ACA § 10107(b)) added Code § 9815(a) and ERISA § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

³ See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010). See also Affordable Care Act Implementation FAQs Part III, Question 1, available at <http://www.dol.gov/ebsa/faqs/faq-aca3.html> and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html.

⁴ The Departments previously addressed HRAs and the requirements under PHS Act § 2715 (summary of benefits and coverage and uniform glossary). See 77 Fed. Reg. 8668, 8670-8671 (February 14, 2012); see also Affordable Care Act Implementation FAQs Part VIII, Question 6, available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html and see page 1 of the Instruction Guide for Group Coverage, available at <http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf>.

⁵ See ACA § 1302(b) for the definition of “essential health benefits”.

2. PRIOR GUIDANCE ON THE APPLICATION OF THE MARKET REFORMS TO HRAS

The preamble to the interim final regulations implementing the annual dollar limit prohibition states that if an HRA is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual dollar limit prohibition, the fact that benefits under the HRA by itself are limited does not fail to comply with the annual dollar limit prohibition because the combined benefit satisfies the requirements. Further, the preamble states that in the case of a standalone HRA that is limited to retirees, the exemption from the requirements of the Code and ERISA relating to the Affordable Care Act for plans with fewer than two current employees means that the retiree-only HRA is not subject to the annual dollar limit prohibition. 75 Fed. Reg. 37188, 37190-37191 (June 28, 2010).

On January 24, 2013, the Departments issued FAQs that address the application of the annual dollar limit prohibition to certain HRA arrangements (HRA FAQs).⁶ In the HRA FAQs, the Departments state that an HRA is not integrated with primary health coverage offered by an employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage that is provided by the employer and that meets the annual dollar limit prohibition. Further, the HRA FAQs indicate that the Departments intend to issue guidance providing that:

(a) for purposes of the annual dollar limit prohibition, an employer-sponsored HRA cannot be integrated with individual market coverage or with individual policies provided under an employer payment plan, and, therefore, an HRA used to purchase coverage on the individual market under these arrangements will fail to comply with the annual dollar limit prohibition; and

(b) an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in the coverage, and any HRA that credits additional amounts to an individual, when the individual is not enrolled in primary coverage meeting the annual dollar limit prohibition provided by the employer, will fail to comply with the annual dollar limit prohibition.

The HRA FAQs also state that the Departments anticipate that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

⁶ See Affordable Care Act Implementation FAQs Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html> and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html.

3. PRIOR GUIDANCE ON THE APPLICATION OF THE MARKET REFORMS TO HEALTH FSAs

Under the interim final rules implementing the annual dollar limit prohibition, a health FSA, as defined in Code § 106(c)(2), is not subject to the annual dollar limit prohibition. See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this Technical Release limiting the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

4. PRIOR GUIDANCE ON THE APPLICATION OF CODE §§ 36B AND 5000A

Section 36B of the Code allows a premium tax credit to certain taxpayers who enroll (or whose family members enroll) in a qualified health plan (QHP) through an Affordable Insurance Exchange (referred to in this Technical Release as an Exchange, and also referred to in other published guidance as a Marketplace). The credit subsidizes a portion of the premiums for the QHP. In general, the premium tax credit may not subsidize coverage for an individual who is eligible for other minimum essential coverage. If the minimum essential coverage is eligible employer-sponsored coverage, however, an individual is treated as eligible for that coverage only if the coverage is affordable and provides minimum value or if the individual enrolls in the coverage.

Coverage provided through Code § 125 plans, employer payment plans, health FSAs, and HRAs are eligible employer-sponsored plans and, therefore, are minimum essential coverage, unless the coverage consists solely of excepted benefits. See Code § 5000A(f)(2) and Treas. Reg. §1.5000A-2, 78 Fed. Reg. 53646, 53658 (August 30, 2013).

Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan and that an employee may use to pay premiums are counted for purposes of determining affordability of an eligible employer-sponsored plan under Code § 36B. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)). Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan are counted toward the plan's minimum value percentage for that plan year if the amounts may be used only to reduce cost-sharing for covered medical expenses and the amount counted for this purpose is the amount of expected spending for health care costs in a benefit year. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). See Q&A 11 of this Technical Release for more explanation of the application of these rules to HRAs and other arrangements.

III. GUIDANCE

A. GUIDANCE ON HRAS AND CERTAIN OTHER EMPLOYER HEALTHCARE ARRANGEMENTS, HEALTH FSAS, AND EMPLOYEE ASSISTANCE PROGRAMS OR EAPS UNDER THE JOINT JURISDICTION OF THE DEPARTMENTS

1. APPLICATION OF THE MARKET REFORM PROVISIONS TO HRAS AND CERTAIN OTHER EMPLOYER HEALTHCARE ARRANGEMENTS

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.

Question 2: How do the preventive services requirements apply to an HRA that is integrated with a group health plan?

Answer 2: Similar to the analysis of the annual dollar limit prohibition, an HRA that is integrated with a group health plan will comply with the preventive services requirements if the group health plan with which the HRA is integrated complies with the preventive services requirements.

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.

Question 4: Under what circumstances will an HRA be integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements?

Answer 4: An HRA will be integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if it meets the requirements under either of the integration methods described below. Pursuant to this Technical Release, under both methods, 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.

Integration Method: Minimum Value Not Required

An HRA is integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if (1) the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits; (2) the employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage); (3) the HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse); (4) the HRA is limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits; and (5) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage under Code § 5000A (see Q&A 10 of this Technical Release) and will therefore preclude the individual from claiming a Code § 36B premium tax credit.

Integration Method: Minimum Value Required

Alternatively, an HRA that is not limited with respect to reimbursements as required under the integration method expressed above is integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if (1) the employer

offers a group health plan to the employee that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii); (2) the employee receiving the HRA is actually enrolled in a group health plan that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii), regardless of whether the employer sponsors the plan (non-HRA MV group coverage); (3) the HRA is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the employer sponsors the non-HRA MV group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a plan maintained by an employer of the employee's spouse); and (4) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

Example (Integration Method: Minimum Value Not Required)

Facts. Employer A sponsors a group health plan and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA group coverage through a family member. Employer A's HRA is limited to reimbursement of co-payments, co-insurance, deductibles, and premiums under Employer A's group health plan or other non-HRA group coverage (as applicable), as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA group coverage. When seeking reimbursement under Employer A's HRA, Employee X attests that the expense for which he seeks reimbursement is a co-payment, co-insurance, deductible, or premium under Employer B's non-HRA group coverage or medical care (as defined under Code § 213(d)) that is not an essential health benefit.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

Example (Integration Method: Minimum Value Required)

Facts. Employer A sponsors a group health plan that provides minimum value and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA MV group coverage through a family member. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA MV group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA MV group coverage and that the coverage provides minimum value.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA MV group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

Question 5: May an employee who is covered by both an HRA and a group health plan with which the HRA is integrated, and who then ceases to be covered under the group health plan that is integrated with the HRA, be permitted to use the amounts remaining in the HRA?

Answer 5: Whether or not an HRA is integrated with other group health plan coverage, unused amounts that were credited to an HRA while the HRA was integrated with other group health plan coverage may be used to reimburse medical expenses in accordance with the terms of the HRA after an employee ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms. Note that coverage provided through an HRA, other than coverage consisting solely of excepted benefits, is an eligible employer-sponsored plan and, therefore, minimum essential coverage under Code § 5000A.

Question 6: Does an HRA impose an annual limit in violation of the annual dollar limit prohibition if the group health plan with which an HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits (but limits the coverage to the HRA's maximum benefit)?

Answer 6: In general, an HRA integrated with a group health plan imposes an annual limit in violation of the annual dollar limit prohibition if the group health plan with which the HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit. This situation should not arise for a group health plan funded through non-grandfathered health insurance coverage in the small group market, as small group market plans must cover all categories of essential health benefits, with the exception of pediatric dental benefits, if pediatric dental benefits are available through a stand-alone dental plan offered in accordance with 45 C.F.R. §155.1065.⁷

⁷ Small group market plans will not be considered to fail to meet qualified health plan certification standards based solely on the fact that they exclude coverage of pediatric dental benefits that are otherwise required under ACA § 1302(b)(1)(J) where a stand-alone dental plan is also available. See ACA § 1302(b)(4)(F) and Question 5, CMS QHP Dental Frequently Asked Questions, May 31, 2013, https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf.

However, under the integration method available for plans that provide minimum value described under Q&A 4 of this Technical Release, if a group health plan provides minimum value under Code § 36B(c)(2)(C)(ii), an HRA integrated with that group health plan will not be treated as imposing an annual limit in violation of the annual dollar limit prohibition, even if that group health plan does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit.

2. APPLICATION OF THE MARKET REFORMS TO CERTAIN HEALTH FSAS

Question 7: How do the market reforms apply to a health FSA that does not qualify as excepted benefits?

Answer 7: The market reforms do not apply to a group health plan in relation to its provision of benefits that are excepted benefits. Health FSAs are group health plans but will be considered to provide only excepted benefits if 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 any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election).⁸ See 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. § 146.145(c)(3)(v). Therefore, a health FSA that is considered to provide only excepted benefits is not subject to the market reforms.

If an employer provides a health FSA that does not qualify as excepted benefits, the health FSA generally is subject to the market reforms, including the preventive services requirements. Because a health FSA that is not excepted benefits is not integrated with a group health plan, it will fail to meet the preventive services requirements.⁹

The Departments understand that questions have arisen as to whether HRAs that are not integrated with a group health plan may be treated as a health FSA as defined in Code § 106(c)(2). Notice 2002-45, 2002-02 CB 93, states that, assuming that the maximum amount of reimbursement which is reasonably available to a participant under an HRA is not substantially in excess of the value of coverage under the HRA, an HRA is a health FSA as defined in Code § 106(c)(2). This statement was intended to clarify the rules limiting the payment of long-term care expenses by health FSAs. The Departments are also considering whether an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition. In any event, the treatment of an HRA as a health FSA that is not excepted benefits would not exempt the HRA from compliance with the other market reforms, including the preventive services requirements, which the HRA would fail to meet because the HRA would not be integrated with a group health plan. This analysis applies even if an HRA reimburses only

⁸ An HRA is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a Code § 125 plan. IRS Notice 2002-45, 2002-02 CB 93.

⁹ Under the interim final rules implementing the annual dollar limit prohibition, a health FSA is not subject to the annual dollar limit prohibition, regardless of whether the health FSA is considered to provide only excepted benefits. See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this Technical Release regarding the restriction of the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

premiums.

Question 8: The interim final regulations regarding the annual dollar limit prohibition contain an exemption for health FSAs (as defined in Code § 106(c)(2)). See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). Does this exemption apply to a health FSA that is not offered through a Code § 125 plan?

Answer 8: No. The Departments intended for this exemption from the annual dollar limit prohibition to apply only to a health FSA that is offered through a Code § 125 plan and thus subject to a separate annual limitation under Code § 125(i). There is no similar limitation on a health FSA that is not part of a Code § 125 plan, and thus no basis to imply that it is not subject to the annual dollar limit prohibition.

To clarify this issue, the Departments intend to amend the annual dollar limit prohibition regulations to conform to this Q&A 8 retroactively applicable as of September 13, 2013. As a result, a health FSA that is not offered through a Code § 125 plan is subject to the annual dollar limit prohibition and will fail to comply with the annual dollar limit prohibition.

3. GUIDANCE ON EMPLOYEE ASSISTANCE PROGRAMS

Question 9: Are benefits under an employee assistance program or EAP considered to be excepted benefits?

Answer 9: The Departments intend to amend 26 C.F.R. §54.9831-1(c), 29 C.F.R. §2590.732(c), and 45 C.F.R. §146.145(c) to provide that benefits under an employee assistance program or EAP are considered to be excepted benefits, but only if the program does not provide significant benefits in the nature of medical care or treatment. Excepted benefits are not subject to the market reforms and are not minimum essential coverage under Code § 5000A. Until rulemaking is finalized, through at least 2014, the Departments will consider an employee assistance program or EAP to constitute excepted benefits only if the employee assistance program or EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.

B. GUIDANCE UNDER THE SOLE JURISDICTION OF THE TREASURY DEPARTMENT AND THE IRS ON HRAs AND CODE § 125 PLANS

Question 10: Is an HRA that has fewer than two participants who are current employees on the first day of the plan year (for example, a retiree-only HRA) minimum essential coverage for purposes of Code §§ 5000A and 36B?

Answer 10: Yes. The Treasury Department and the IRS understand that some employers are considering making amounts available under standalone retiree-only HRAs to retired employees so that the employer would be able to reimburse medical expenses, including the purchase of an individual health insurance policy. For this purpose, the standalone HRA would constitute an eligible employer-sponsored plan under Code § 5000A(f)(2), and therefore the coverage would

constitute minimum essential coverage under Code § 5000A, for a month in which funds are retained in the HRA (including amounts retained in the HRA during periods of time after the employer has ceased making contributions). As a result, a retiree covered by a standalone HRA for any month will not be eligible for a Code § 36B premium tax credit for that month. Note that unlike other HRAs, the market reforms generally do not apply to a retiree-only HRA and therefore would not impact an employer's choice to offer a retiree-only HRA.¹⁰

Question 11: How are amounts newly made available under an HRA treated for purposes of Code § 36B?

Answer 11: An individual is not eligible for individual coverage subsidized by the Code § 36B premium tax credit if the individual is eligible for employer-sponsored coverage that is affordable (premiums for self-only coverage do not exceed 9.5 percent of household income) and that provides minimum value (the plan's share of costs is at least 60 percent). If an employer offers an employee both a primary eligible employer-sponsored plan and an HRA that would be integrated with the primary plan if the employee enrolled in the plan, amounts newly made available for the current plan year under the HRA may be considered in determining whether the arrangement satisfies either the affordability requirement or the minimum value requirement, but not both. Amounts newly made available for the current plan year under the HRA that an employee may use only to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan count only toward the minimum value requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations, to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). Amounts newly made available for the current plan year under the HRA that an employee may use to pay premiums or to pay both premiums and cost-sharing under the primary employer-sponsored plan count only toward the affordability requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)).

Even if an HRA is integrated with a plan offered by another employer for purposes of the annual dollar limit prohibition and the preventive services requirements (see Q&A 4 of this Technical Release), the HRA does not count toward the affordability or minimum value requirement of the plan offered by the other employer. Additionally, if an employer offers an HRA on the condition that the employee does not enroll in non-HRA coverage offered by the employer and instead enrolls in non-HRA coverage from a different source, the HRA does not count in determining whether the employer's non-HRA coverage satisfies either the affordability or minimum value requirement.

For purposes of the Code § 36B premium tax credit, the requirements of affordability and minimum value do not apply if an employee enrolls in any employer-sponsored minimum essential coverage, including coverage provided through a Code § 125 plan, an employer

¹⁰ See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010).

payment plan, a health FSA, or an HRA, but only if the coverage offered does not consist solely of excepted benefits. See 26 C.F.R. §1.36B-2(c)(3)(vii). If an employee enrolls in any employer-sponsored minimum essential coverage, the employee is ineligible for individual coverage subsidized by the Code § 36B premium tax credit.

Question 12: Section 125(f)(3) of the Code, effective for taxable years beginning after December 31, 2013, provides that the term “qualified benefit” does not include any QHP (as defined in ACA § 1301(a)) offered through an Exchange.¹¹ This prohibits an employer from providing a QHP offered through an Exchange as a benefit under the employer’s Code § 125 plan. Some states have already established Exchanges and employers in those states may have Code § 125 plan provisions that allow employees to enroll in health coverage through the Exchange as a benefit under a Code § 125 plan. If the employer’s Code § 125 plan operates on a plan year other than a calendar year, may the employer continue to provide the Exchange coverage through a Code § 125 plan after December 31, 2013?

Answer 12: For Code § 125 plans that as of September 13, 2013 operate on a plan year other than a calendar year, the restriction under Code § 125(f)(3) will not apply before the first plan year of the Code § 125 plan that begins after December 31, 2013. Thus, for the remainder of a plan year beginning in 2013, a QHP provided through an Exchange as a benefit under a Code § 125 plan will not result in all benefits provided under the Code § 125 plan being taxable. However, individuals may not claim a Code § 36B premium tax credit for any month in which the individual was covered by a QHP provided through an Exchange as a benefit under a Code § 125 plan.

IV. APPLICABILITY DATE AND RELIANCE PERIOD

This Technical Release applies for plan years beginning on and after January 1, 2014, but the guidance provided in this Technical Release may be applied for all prior periods. If legislative action by any State, local, or Indian tribal government entity is necessary to modify the terms of a pre-existing HRA, a health FSA that does not qualify as excepted benefits, an employer payment plan, or other similar arrangement, sponsored by any State, local, or Indian tribal government entity, as an employer, to avoid a failure to comply with the market reforms (including action to terminate such arrangement) and such action may only be taken by a State, local, or Indian tribal government entity legislative body, the applicability date of the portions of this Technical Release under which such arrangement would otherwise fail to comply with the market reforms is extended to the later of (1) January 1, 2014, or (2) the first day of the first plan year following the first close of a regular legislative session of the applicable legislative body after September 13, 2013.

¹¹ This rule does not apply with respect to any employee if the employee’s employer is a qualified employer (as defined in ACA § 1312(f)(2)) offering the employee the opportunity to enroll through an Exchange in a qualified health plan in a group market. See Code § 125(f)(3)(B).

V. FOR FURTHER INFORMATION

The Departments have coordinated on the guidance and other information contained in this Technical Release. The guidance in this Technical Release is being issued in substantially identical form by the Treasury Department, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this Technical Release. Questions concerning the information contained in this Technical Release may be directed to the IRS at 202-927-9639, the DOL's Office of Health Plan Standards and Compliance Assistance at 202-693-8335, or HHS at 410-786-1565. Additional information for employers regarding the Affordable Care Act is available at www.healthcare.gov, www.dol.gov/ebsa/healthreform, and at www.business.usa.gov.